Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Schrum vale Month Physician/ naev 30 Medical 4c County of Death 4a. Facility Name (it not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Sudley 4838 8. Date of Birth g. Birthplace (State or Foreign If Under 24 Hrs. . Age (In yrs. last birthday) Funeral <sup>Year]</sup>1947 Months Days July 27 1 XM 2 □ F Hours West' Virginia 133-36-8290 64 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No West River Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20778 4838 Sudley Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Xyes 2 No. 8If Yes, Give Year or Dates. 1911 Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) R.A. Michaels Fork Lift Operator Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Mills Albert Schrump 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4838 Sudley Road West River, Gretchen A. Decker/ Sister 20b. Place of Disposition (Name of cemetry, crematory or other place)
National Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 7/6/2012 Laurel. 4 ☐ Donation 5 ☐ Other (Specify) and Address of Facility Fleck Funeral Home Signature of Funeral Service Licensee 7601 Sandy Spring Road Laurel, MD 20707 lille 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between and Death Immediate Cause (Final ancer years Pnysician disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Live Birth 2 - Fetal death Month Day Year in the past 12 months? jo Pregnant at time of death 2 No been signed by the sahould be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s death? 2 X No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 🔀 Residence 6 🗆 Other (Specify) 2 X No ပ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: A Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0

State Registrar 8600 snowden River pkwy #301, columbia, mD 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

56531

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 3, 2012 21:08 Gwendolyn Baltimore Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 M 2 F Months Days Hours Min. June 17, Year 1944 Virginia 68 231-54-9384 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d, Inside City Limits 10c. City, Town or Location Director Maryland Hyattsville Prince George's 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20782 U.S.A. 1701 Dekalb Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 10 No 1982-Black, White, etc. þ 1 Never Married 2 X Married **Black** Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: 1998 Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) D.C. Government Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henrietta Baltimore Randolph Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Dekalb Court Hyattsville, Maryland 20782 19a. Informant's Name/Relationship (Type, Print) 1701 Dekalb Court Donald Smith (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Good Hope Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State July 12,2012 Front Royal, Virginia 4 Donation 5 Other (Specify) 21. Son ture of Funeral Service Licens 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th Street, N.W. Washington, D.C. 20011 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final REFRA MAGT Physician SE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list of nettillins Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury RFORATED ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? j Year Pregnant
Unknown Pregnant at time of death signed by the a 9 Unknown Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by RENAL 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed RESPIRATORY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has page 2 performed?

Yes 2 No death? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. Completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 24 No 1 \sum Yes 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending Natural work? 1 ☐ Yes 2 ☐ No. Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Piotr Wyrwinski, MD 7600 Carroll Avenue Takoma Park, Maryland

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

109

29d. Date signed (Month, Day, Year)

20912

2012

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 7:15 р м Joseph Richard Switalski July 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Cecil Port Deposit 1 Center Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 10, 1950 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Pennsylvania 1**X** M 2 □ F Hours 181-40-2975 61 Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Port Deposit 1 🌠 Yes 2 ☐ No Cecil Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1 Center Street 21904 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Cecil Woods Elementary/Seconday (0-12) Twelve Years College (1-4 or 5+) North East, Maryland Maintenance Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Catherine Sokolowski Joseph Switalski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa A. Switalski (wife) 110 Hunter Court, Havre de Grace, Maryland 21078 20c. Location - City or Town, State West Chester, Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State R.A.Ferris & Co., Inc. 07/05/12 4 Donation 5 Other (Specify) Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Signature of Funeral Service License omasm. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cong est: disease or condition resulting in death) Due to (or a a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery Month Day Year n Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension Unknown vailable

Physician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

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Director

Funeral

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permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

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within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

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Medical

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The law requires that the death certificate be

P.O. Box 68760

Records,

Division of Vital

Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)
art II. Other significant condition	s contributing to death but not resulting in	n the underlying cause given i

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24a. Was an autopsy performed? 1 ☐ Yes 2	24b. Were autopsy findings a prior to completion of cadeath? 1 ☐ Yes 2 ▼No
k only one)	

<i>j</i> ·		
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examiner?	1.13-b-b	0.11

Specify)

21921

T LI Yes 2 12	NO INO	1 ☐ Inpatient 2 ☐	ER/Outpatient	3 ∐	DOA 4	4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)					
7. Manner of Death		28a. Date of injury	28b. Time of		28c. Injury at		28d. Describe how injury occurred				
1 Natural 2 Accident	5 Pending Investigation		injury	М	work? 1 ☐ Yes	2 🗆 No					
3  Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At h		t, facto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				

9a. Certifi	er 1 Certifying Physici	an: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
(Chec		On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner sta
only o	no) 2 Cartifying Nurse F	practiceners. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of cert	ifier n		
> ggh	Pullar	MO	
30. Name and address of pers			rint)

10065013

29d. Date signed (Month, Day, Year)

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Stat	te
Registra	ar

31. Date filed (Month, Day,

32. Regist/ar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hydiene

		1	For State	State of Mar		ertificate of			icitairiy	Rea. No.		
			Registrar  1. Decedent's Name (First, Middle, Las	st)					2. Date of De	ath		3. Time of Death
	Physicia Medic		Edward Daniel Sno	ovel, Sr.					July	6 Day	2012 Year	6:45A <sup>M</sup>
1	Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, o					County of Death	
1			231 North St. Aug			Chesap					Cecil	
	Funeral		5. Social Security Number 6. S		n yrs. last birthday)	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da		9. Birthp Coun	blace (State or Foreign try)
ь.	Director		187-30-2631 Usual Residence of Decedent	<b>X</b> M 2 □ F	75 Yrs.				01-09-1	1937	Penns	ylvania
	nd ihow at	ъ	10a. State 10b. County	1	0c. City, Town or L	ocation					1	0d. Inside City Limits
	laryla 3a-f s ified	ect	Maryland Cecil		Chesapea	ake City						1 ☐ Yes 2 💢 No
	or 28		10e. Street and Number			10f. Zip Code				10g. Citi	zen of What Cour	ntry?
	with s 23a ust b	Funeral Director	231 North St. Au	gustine Roa	d	21915				Unite	ed State	S
	death item: ier m		11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13	Was Decedent of I	Hispanic C an, Mexic	rigin? (Spe an, Puerto	cify Yes or No- Rican, etc.)	.	14. Race - Americ Black, White,	
036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2be notified at other traumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No					Specify: Whit	
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m 0	Page nent c ant: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			Cemetery	.00)	07-1	4-2012	Ga1	ena, Mar	y1and
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Paneral Service Licen	Su 12/2		22. Name and Addr						
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	5 Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar		12 car	1 -	146	VAC U	uc	140	DIUTO
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Randy Sisler		I- For State Registrar	St	ate of Maryl	and / D		nent of <i>cate of</i>			Ment	al Hy		leg. No.	2	]	2 6.	
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		Garrett Mem	norial					Oakla	nd	d				Garrett			
Funeral Director		5. Social Security N		6. Sex	7. Age (Ir	n yrs. last b	_	If Unde Months		If Under Hours	24Hrs. Min.	8. Date of Bi	•		Foreig		
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Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other tr	- 1	1 X Burial 2 Donation 5		n 3 Removal f	rom State	Memo	move by orial	erpecent l Ga:	unty rder	ns	7/	6/12	0	akla	nd,	Mary	land
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Division of Spiral or Attending sours after death.  neral Director: Afferding sours after death.	2	2 Accident 3 Suicide	6 Coul	a not be	ce of Injury	- At home,	farm, stree	t, factory,	office bui	ilding, etc.	2	8f. Location (		nd Number	r or Rur	al Route Nun	nber, City
Divis  Hospital or A  24 hours after Funeral Dire etely filled in b	5	4 Homicide 29a. Certifier			) Single							60 Glendale	Road,				
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To the within To the comple	Ě	29b. Signature and t		and manner	stated				License							th, Day, Year,	)
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-	, [	30. Name and addre						W Ball	imoro	Street	Raltim	ore MD 2	1222			•	
Stat	e i	Pamela E. S 31. Date filed (Monti			gistrar's S	ignature			.iiiiore	Sireet,	Dailim	ore, MD 2	1223				-
Registra	ar	31. Date filed (Monti	JUL - E	i 2012 🛮	enous	A.	10	Mal									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY Day 2012 Year WILLIAM LEWIS SUTPHIN, JR. 9 10:40A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY 22341 MT. EPHRAIM ROAD DICKERSON If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🗹 M 2 🗆 F Months Hours 0770671940 WASH. 72 214-36-4243 DC **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director MD MONTGOMERY DICKERSON 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22341 MT. EPHRAIM ROAD 20842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married 1 Yes <sup>2 □</sup> № 1963 Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 ☑ No Specify: WHITE er than "natural", the Medical Exa Specify: Year or Dates. 1965 Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) FINE CARPENTRY College (1-4 or 5+) Elementary/Seconday (0-12) CARPENTER 12 marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ WILLIAM LEWIS SUTPHIN, SR. FRANCIS CRAMPTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTIE SUTPHIN / SPOUSE 22341 MT. EPHRAIM RD., DICKERSON, MD 20842 and 2 s Health a item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State STAUFFER CREMATORY July 11,2012 4 Donation 5 Other (Specify) FREDERICK, Signature of tyneral Service Licensee 22. Name and Address of Facility P.O. HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death MONTHS Immediate Cause (Final End stage liver disease ⊋πysiciaπ/ disease or condition resulting in death) Medical Due to (or as a consequence of) ≟xaminer Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Box 68760 as i attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ρď Month Year 5 Other (specify) Pregnant at time of death signed by the aid be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cirrhosis 1 Tes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of Portal vein thrombosis 24a. Was an cate has autopsy performed? Yes 2 No death? Non alcoholic steatohepatitis 1 Yes 2 No certificate Hospital or Attending Physician: 7
 4 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5  $\boxtimes$  Residence 6  $\square$  Other (Specify) Hospital: 1 ☐ Yes 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1011

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signature

March ..

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Rohrer,

D 37197

15 West 7th St./ Frederick, Maryland

July 10, 2012

amend #26 Per PHY 6929 7/26/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) ARKADIY SHERMAN 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE N/ASocial Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country UKRAINE 1 🗓 M 2 🗆 F Months Days Hours 01711171929 217-35-8498 83 Yrs. **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6810 PARK HEIGHTS AVENUE, 21215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed WHITE 2 should be filed within 72 hours; th and Mental Hygiene. ?? is marked other than "natural traumatic event, the Medical Extra Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **TEACHER** EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ASSIR SHERMAN traumatic EUGENIA SHPIGEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra MINA SHERMAN / WIFE 6810 PARK HEIGHTS AVENUE. #403, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 07/25/2012 BALTIMORE, MD 21. Signature of Luneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final miocardial Physician. disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of physician a the burial-t Physician/Medical as 1 attending IF FEMALE; use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Yes 1 Lyes 2 L 9 Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient XX ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifu D0054746 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Or. A. POKOV-6821 Reissershown Rd #206, Balfimore, maguests

31. Date filled (Marth, Day, Veer) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 20ĬŽ Physician/ July 11:45pM Mary M. Schenke Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Homewood at Crumland Farms Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, **Funeral** (Month, Day, Year) 218-20-1207 Director 1 M 2 X F 85 March 10,1927 New York Usual Residence of Decede 10d. Inside City Limits 28a-f show 10b. Count 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 X Yes 2 No Frederick Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral "natural", or items 23a United States 21702 7401 Willow Road # 437 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. 1 Yes 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Blair House Assistant Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If Item 27 is marked or any injury or other traumatic even once. Kathryn Handrahan John Moran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12615 Eldrid Court, Silver Spring, Maryland 20904 Jeanne S. Warth / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory Inc.7/11/2012 Frederick, Maryland. Other (Specify) 4 Donation 5 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Signature Homes P. A. Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on that d the death. Do not enter Interval Between Immediate Cause (Final Phytician/ Medical 116 disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death detached for in the past 12 months? Pregnant at time of death 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe filled in by the funeral director, page 2 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA \*\*\*\* Fursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 1 🗌 Yes 24 hours after death. Funeral Director: A Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practition best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tile of certifier D16428 Idress of person who completed cause of death (Item 23a) (Type, Print)

12

Registrar
DHMH 17 Rev 06-2011

State

Casper E. (31. Date filed (Month, pa

Vine MD 300 West 9th Street, Frederick, Maryland 21702

gistrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiana

		1	For State	State of Mary	•	artment of H tificate of D			ene eg. No. 2 ()	12	21009
		-	Registrar  1. Decedent's Name (First, Middle, Last)			imouto of D	- Jan	2. Date of Death	1		3. Time of Death
	Physicia Medic	al L		rison Sno	WC			July	8 <sup>Day</sup> 2012		2:23 PM
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	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplac	ce (State or Foreign
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	and show	tor	10a. State 10b. County	10	c. City, Town or Lo	eation				10d	. Inside City Limits
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	with the		126 Lauren Court			10f. Zip Code 21703	3	I .	09. Citizen of W United		1
	leath v	12	11. Marital Status	12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No- Rican, etc.)		- American	
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Mar	2 shouth and in shouth and in shouth		19a. Informant's Name/Relationship (Type Phyllis Andrews /			ng Address <i>(Street a</i> <b>Green Va</b> l			-		
ē,	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	- 2	20b. Place of Dispo	· · · · · · · · · · · · · · · · · · ·			20c. Location -		
Baltimore, Maryland 21215-0036	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Stauffer	Cremator	y Inc.7/1	4/2012	Freder	ick,Ma	ryland.
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Box 6	death certific he attending   ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin	Fetal death 3	Ectopic pregnand Other (specify)	у		23d. Date Mor	e of delivery ath Da	ay Year
	the des	hysi	1 Ves 2 No 9 Unknown	9 🗆 Unknown							
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3ec	The law ate has page 2:	omo						autops perform	med2- d	leath?	bletion of cause of
tal	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:		26. Pl	ace of Death (Chec	k only one)			
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on o		ficat	Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	ear) injury	M 1 🗆	? Yes 2 ☐ No				
Division	pital or Attendous after deatlers after deatlers birector:	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		eet, factory, office		28f. Location (St City or Town		r or Rural R	oute Number,
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	To the Hosp within 24 ho To the Fune completely f	Σ	only one) 3 L Certifying Nurs 29b, Signature and title of certify	e Practitione): 10 the be	est of my knowledge	29c. License			9d. Date signed		
Ø			1 200			MDT	200FC	22	79	12	
_	6		30. Name and address of person who c	ompleted cause of deat			st 7th St	reet, F	rederic	k,MD 2	21701
Г	Sta Registr		31. Date filed (Month, Day, Year) 1 2	32. Registrar's	Signature	barker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1 per MD FCHD TM #17 & 194 per FH FCHD TM 7/20/12

state of Maryland / Department of Health and Mental Hyglene/12 Reg. No. 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August E. Stigler Physician/ July 7, 2012 2:30 p. M August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Adamstown Frederick Buckingham's Choice Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, June 3, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Funeral 212-12-1912 Months 92 1920 Director 1X M 2 ☐ F Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. It start if if item 27 as or 28a-1 shouly or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Maryland Frederick Adamstown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2001 Buckeystown Pike USA 21710 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married 2 No 1943 1 Yes, Give 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify: Completed 3 X Widowed 4 Divorced 1945 Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Construction Building contractor Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) August Stigler ပ Anna Veith August Stigler, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Buckeystown Pike, Adamstown, Maryland 19a. Informant's Name/Relationship (Type, Print)
Stacey Schoo — Daughter
Stacey Bhoo daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 7-15-2012 Frederick, Maryland Resthaven Memorial 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Dicensee Stauffer Funeral Home 22. Name and Address of Facility 21702 Frederick, Maryland 1621 Opossumtown Pike, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. In terms of merity of Cause (Disease or injury Examine Due to (or as a consequence of) and that initiated events resulting in death) Last use as the burial-tra Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death Pregnant : been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death. Funeral Director: After this certificate has etely filled in by the funeral director, page 2 autopsy performed? Yes 2 X No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5  $\square$  Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the the only op 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058726 7-10-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yvette Lopez-Warren MD 21773 15+1 Myersville Ventrie D 31. Date filed (Month, Da

Registrar

State

egistrar's Signature

resure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 23a, per me, g931 9-18-12 sm
State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#19b, per FH, FCHD, LE Certificate of Death 7/11/12 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PM Stephen Stanley Sadowski 2012 5:00 July 5, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Frederick 4b. City, Town, or Location of Death Examiner 10696 Salem Avenue Thurmont 5. Social Security Number 9. Birthplace (State or Foreign Country) Massachusetts If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Nov 9, 1953 1 M 2 □ F 58 **Director** 214-48-3747 Usual Residence of Deceder show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director Thurmont 28a-f s Maryland Frederick 1 Yes 2 X No 10e. Street and Number 5 10f. Zip Code 10g Citizen of What Country? by Funeral 23a 10696 Salem Avenue 21788 USA iral", or items 2 Examiner mus within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc 1 Never Married 2 K Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify. "natural" 3 Divorced 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) l Hygiene. other than Elementary/Secondary (0-12) College (1-4 or 5+) Florist Delivery person Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Stanley Sadowski Eileen Jandron pe 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 1:06:96g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Diane Sadowski - wife 10646 Salem Avenue, Thurmont, Maryland 21788 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 Burial 2 xxremation 3 Removal from State Stauffer Crematory 7-11-2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Fun eral Home 21. Sign re of Funeral Servic 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Directo for este consequence offi cause. Enter Underlying that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Por in the past 12 months? Month Day Year Yes 2 No detached the 9 Unknown g Unknown P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Division of Vital Records, The law requires 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy perform certificate Yes Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurry Certificate: 28c. Injury at 1 🔲 Natural 5 Pending work? 1 ☐ Yes 2 X No 2012 s after death Accident Investigation Unknown Shor 3 Suicide 4 Homicide 6 Could not be nurmout, MD Place I Injury - At hor building, etc. (Specify) - At home, farm, street, factory, office Location (Street determined home City or Town, State) 10696 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year,

DHMH 17 Rev 06-2011

Registrar

rson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 11:41 A M July Stokes Howard Lawrence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 87 Director 577-26-0531 1 X M 2 | F 1925 Washington, DC June 23, Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State notified at Director 1 X Yes 2 No Takoma Park Prince George's Md 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō . Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.

The state if item 27 is marked other than "natural", or items 23a on item 23a or other trannatic event, the Medical Examiner must be a fundy or other traumatic event, the Medical Examiner must be. by Funeral USA 20912 1026 East West Highway 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc 1 X Yes 2 ☐ No If Yes, Give 1 Q 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White rr yes, Give Year or Dates. 1943–45 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Plummers Local 5 College (1-4 or 5+) Elementary/Secondary (0-12) Plummer Washington DC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Mae Henley William Benjamin Stokes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Bayside Dr. Stevensville, Md 21666 19a. Informant's Name/Relationship (Type, Print) Thomas Stokes / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 🛮 Burial 2 🗌 Cremation 3 🗎 Removal from State Fort Lincoln Cemetery 7/15/2012 Brentwood, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Dreta 3401 Bladensburg Rd Brentwood, Md Marcis 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and for use as the burial-tra Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) been signed by the s should be detached a I I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: A
completely filled in by the 1 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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only one) 29b. Signature and title of certifie

the

Registrar DHMH 17 Rev 06-2011 (Type, Print)

deress of person who completed cause of death (Item 23a)

32. Registra

29d. Date signed (Month, Day, Year)

2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TIMOTHY NATHANIEL THOMPSON Medical 4a. Facility Name (if not institution, give street and number, 4b, City, Town, or Location of Death 4c. County of Death **Examiner** LANHAM HOSPITAL COMMUNITY PRINCE GEORGE'S DOCTORS Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Director 223-64-9822 1 X M 2 D F 61 MAY 29, 1951 BLACKSTONE, VA. ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Prince Georges Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States #8 20785 2408 Brightseat Rd. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 Yes 2X No
If Yes, Give
Year or Dates. 1 Never Married 2 XMarried þ filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: Black 3 Widowed 4 Divorced Completed Hygiene. other than "natura ent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Rigger marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Richard Thompson unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

#8 Landover, Md. 20785 19a. Informant's Name/Relationship (Type, Print) 2408 Brightseat Rd. #8 Landover, Md. Page 1 and 2 siment of Health a Janice C. Thompson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Ft. Lincoln 7/13/2012 Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Alexander S. Pope / P.A.
5538 Mariboro Pikė/P.Forestville, Md. . Signature of Funeral Service License 20747 Part 1. Inter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dreumonia Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner 0 Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury Due to for as a contract uence of Exami burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical death certificate be Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes ≥ 1 9 ☐ Unknown g Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law r 24 hours after death.
 Funeral Director: After this certificate has b page 2 autopsy death? performed? Yes 2 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation completely filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a, Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of q 29d. Date signed (Month, Day, Year) D0068976 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 8118 Good heick Rd., Carham, MD. 20104 ene, mD ev 32. Registrar's Signature

Registrar

1 3 2912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ annie lerr 3.38 PM 07 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care PG LARGO ocial Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Hours Min. 228-38-5097 Director 1 M 2 XF 79 1/19/1933 VA Usual Residence of Dece 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 □ No WASHINGTON DC ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a US 1932 GOOD HOPE RD. 20020 SE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. ori þ 1 Never Married 2 😾 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 "natural", Specify: 3 Widowed 4 Divorced Completed BLACK Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the PRIVATE HOME MAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ ARTHUR TAYLOR ADA HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; if item 27 is any injury or other traunonce. HOWARD TERRY SR./HUSBAND 1932 GOOD HOPE RD, SE, WASHINGTON, DV 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) LINCOLN CEMETERY 7-12-12 BRENTWOOD, MD 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Licensee 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 MU623 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Cardio my op ath disease or condition Medical resulting in death) Examiner Congestive Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician Physician/Medical abetes mellitus that the death certificate be P.O. Box 68760 the as ding IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Day Vear Pregnant at time of death 1 ☐ Yes 2 ¥ 9 ☐ Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by E mboli umunary Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 2 🗌 No Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifical funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours to the to the total to the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying planse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a of certifie 29d. Date signed (Month, Day, Year) 07-07-2012 D 51520 O ss of person who completed cause of death (Item 23a) (Type, Print) SOUTHER AVE. SE WASHINGTON DC BAHRAM PISHDAY, M.D. 1328 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 1 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 July P M 1:10 Susan M. Talley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford <u> Harford Memorial Hospital</u> Havre <u>De Grace</u> 7. Age (In yrs. last birthday, If Under 24 Hrs. Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛭 F 6/20/1957 213-66-5228 Director Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c, City, Town or Location Director 1 🗌 Yes 2 🎦 No MD Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21911 USA 268 Harrington Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Line Worker Pharmaceutical Mfg. 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Clifford George A. Hunt and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is <u> Michael J. Talley - husband</u> Harrington Road, Rising Sun, MD 21911 Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7/11/2012 Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rising Sun, MD Foard Funeral Home. Signature of Funeral Service Live see 22. Name and Address of Facility R.T. Foard Funeral Home, PA Rising Sun, MD 21911 Queen Street, S. 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Immediate Cause (Final Onset and Death Physician Orona disease or condition resulting in death) Medical Due to (or as a consequen of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔍 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Tes 2 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ျင 1 Inpatient 2 A/Outpatient 3 DOA Certificate: 27. Manner of Deat 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Hospital or Attending 5 Pending 1X Natural work' **Division** 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) ē erson who corroleted cause of death (Item 23a) (Type, Print) 30. Nan and address of 301 31. Date filed 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 45 umberland Allegan 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 232-60-5193 Country) **Director** 1 🗆 M 2 🗙 F 28a-f show Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten Examiner ı 14. Race - American Indian, Black, White, etc. Yes 2 No Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examis one. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Wildowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OMMUNI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Du o (or as a conseq (ence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (visease or injury that initiated events Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has 2 🗌 No 1 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: Natural (Month, Day, Year) 5 Pending М Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD D72514 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WMHS-12500 WILLIAMER RD- 21502 CUMBERLAND Kelly State JUL - 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>012</u> Physician/ Tichnell June 29. Daryl Abner 4:04 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett 357 Virts Road Swanton 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Days Hours Min 219-34-6295 74 Director 1 XM 2 F 1937 Oct. Usual Residence of Dece or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f sho Medical Examiner must be notifled at Director MD Garrett Swanton 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21561 United States death with 357 Virts Road 12. Was Decedent Ever in U.S. Armed Forces? 10.6 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Types 2 No 1962 If Yes, Give 1065 Black, White, etc. 1 Never Married 2 Married ģ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. specify: white 1965 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry e filed within al Hygiene. ther than "n. t, the Mo (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Paper Manufacturer Maintenance should be filed with and Mental Hygien is marked other th 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Paugh Abner Kelly Tichnell Iva permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic o 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 357 Virts Road, Swanton, Maryland 21561 Eloise Tichnell/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Tichnell Cemetery 07/03/2012 Swanton Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Source Licenses 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of): Examiner 2 years Small Cell Carcinoma Lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and shed for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day 5 Other (specify) Month Year be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Completed 1 Yes 2 No 3 Probably 4 Unknown is certificate has been s. I director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 XN Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \textbf{X} Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 🖾 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral The Hospital or Attending Privithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical within 24 hound To the Funer completely file 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 2 June 29, 2012 H26154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4

DHMH 17 Rev 06-2011

State

Registrar

Oakland, MD 21550

Paul Miller DO 69 Wolfe Acres Dr.,

82. Registrar's Signature

31. Date filed (Month, Day, Year)

JUL - 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 ea Physician/ Grover Cleveland Tate Tul Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital aure Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 454-22-1229 90 Director 1 🕱 M 2 🗆 F Yrs May 27, 1922 Celina, Texas 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No Prince George's Beltsville 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? Funeral or items 23a 4800 Naples Avenue 20705 USA permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural" 3 XWidowed 4 Divorced WWII other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) DC Health Inspector DC Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Grover C. Tate Kennon Childress 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Naples Ave., Beltsville, MD 20705 Nancy Tate - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 7/8/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 FAG Rogers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Infarction Physician/ disease or condition resulting in death) Medical Due t (or as a consequence of): teriosclerotic Heart Disease Examiner Years Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending account. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 2 No 1 Yes 2 L 9 I Inknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dependent Diabetes Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Bladder 24a. Was an Cancer autopsy performe Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 X No 1 Inpatient 2 KER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 201 VA. Van Dusen Rd. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 aurel, 207017 MD Regional Hospita Burguieres. Laurel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend PI, b perato of Maryland 7 beartment of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louis Randolph Violette 2012 8:40 Ju1v Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 3711 Varnum Street Prince George's Brentwood 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) **Director** 1 ★ M 2 □ F 579-16-2419 97 1915 Washington, DC 23, Feb. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3711 Varnum Street 20722 USA 'natural", or items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🖾 No Specify If Yes, Give Specify. Completed 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Bakery Industry Baker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Violette Katie Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Supamas Violette / Wife 3711 Varnum Street, Brentwood, MD 20722 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 

Burial 2 ☐ Cremation 3 ☐ Removal from State ò injury 4 Donation 5 Other (Specify) Brentwood, Maryland 7/9/2012 Fort Lincoln Cemetery Signature of Fuperal Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval P Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ renal Fallyre disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Atherosclerotic cardiovascular disease Sequentially list conditions, Examine Cité to lor as a nonsequippe on It any leading to immediate cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ρ in the past 12 months? Day 5 Other (specify) Month Year Pregnant at time of death 2 No detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) Hospital: 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA completely filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 X Natural 5  $\square$  Pending work? Division 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D23743 7/9/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 7525 Greenway Center Drive, Suite 205, Greenbelt, MD 20770 Martin D. Weltz. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

23 H

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201<sup>2</sup> JULY 7:00 AM OLGA MARINA VALLE VALLE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 Days Hours (Month, Day, Year) Director HONDURAS 53 1/10/1958 Usual Residence of Decedent 28a-f show if Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director SAN PEDRO SULA 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14TH ST BARAHONA; 9TH AVE BARRIO PAZ Funeral HONDURAS 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 X Yes 2 ☐ No SpecifyHONDURAN Specify: 3 - Widowed 4 - Divorced HISPANIC Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other tt 12TH ENTREPRENEUR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JESUS VALLE PINTO ROSALINA VALLE 19a. Informant's Name/Relationship (Type, Print) 1ºTHilling 1ddress of the arriver barkki but pay bob Sika Honat, house #41 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra KAREN LICONA VALLE/DAUGHTER SAN PEDRO SULA, HONDURAS 20b. Place of Disposition (Name of cemetery, crematory or other place)

JARDINES DEL RECUERDO 7-17-2012 20a. Method of Disposition 20c. Location - City or Town, State 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State SAN PEDRO SULA, HONDURAS 4 Donation 5 Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Uneral Service Licensee 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 M01623 23a. Part 1. Enter 1 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Shock Days Medical resulting in death) Examiner transplantation Cell Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Leukemia resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a d be detached f 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Graff Versus Host Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I; page 2 s autopsy performed? Yes 2 \(\subseteq\) No 1 Yes 2 No X Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 X No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number · Kemon O Maryland 3 D

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

KENNETH E.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 07 2012 1345 <u>Mildred E. Willhide</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 102 Timber Ridge Drive, Apt. Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days Min (Month, Day, Year) 219-16-3976 **Director** 1 □ M **2**√□ F 88 09/05/1923 M or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 102 Timber Ridge Drive, Apt. 21157 USZ 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc or. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wesley Poole Nettie Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Willhide/son 694 S. Springdale Road, New Windsor, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadow Ridge Mem. Park 07/26/2012 Elkridge, MD 21. Signature of uneral Service Licensee 22. Name and Address of Paritytts Funeral Home & Chapel, PA Maile 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. or respiratory arrest,

Approximate Interval Between Interval Between Page and Death Page and De Immediate Cause (Final ongeshure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exam Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown þ ate has been signed I page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c Injury at work? 28d. Describe how injury occurred Certificate: the Hospital or Attending Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 7/23/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER MANULANCE 2015) 285 STONER AUTHUR THOMAS U\_ GALVA IUM. 31. Date filed (Month, Day, 32. Registrar's Signature

State

Registrar

27 2012

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 1245am Physician Whatsell ouse /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Oakland 27200 ONRO If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
WV Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2×F Months Days 70 5311 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it is Nedical Examinal must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2 XNo Director Terra Alta Preston WV 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 26764 U.S. Saltlick Rd Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify: Specify: White <u>\$</u> 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Alice Bowman Murphy William Henry Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 308 Burnside Camp Rd, Terra Alta, WV 26764 Debra Barnard Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/6/2012 Terra Alta, WV Terra Alta Cemetery 22. Name and Address of Facility
Arthur H. Wright Funeral Home
105 Highland Avenue, Terra Alta, WV 26764 21. Signature of Funeral Se ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Part 1. Enter the disease, or complice shock, of heart failure. List only one Immediate Cause (Final Smins Physician 40 CA50 resulting in death) /Medical Due to or as a consequence of): Examiner mari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examine The law requires that the death certificate be executed ysician and e burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician d be detached for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 m r ine past 12 mor ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ■No 24a. Was an has certificate 1 □Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient Certification: To 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 30. Name and address of person who completed ca se of death (Item 23a) (Type, Print) Savopollos 251 1446

State Registrar 50+ierre

32. Registrar's Signature

OAKland

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Physicia	_	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death					
ledical Exami		David James Walston	Month July 2, 201		1200 hrs					
(A)		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	ath					
		Peninsula Regional Medical Center Salisbury  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I ff Under 24Hrs.	8 Date of Birth	n(MM/DD/YYYY) 9. E	Sirtholace (State or					
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arylar 8a-fs	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	ountry?					
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp		14. Race - Am White, etc	erican Indian, Black,					
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MD and 2 sho alth and m 27 is		Bonnie Walstonspouse 5834 Airport Rd., Saliza Amethod of Disposition 20a. Method of Disposition (Name of cemetery,	sbury,	Maryland 20c. Location - City						
or Hee		1 X Burial 2 Cremation 3 Removal from State crematory or other place)								
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Baltimore, permit. Pages I a Department of He Important: If ite		27 Signature of Funeral Service Licensee  22. Name and Address of Facility Holloway Funeral	ome P.A.	Ma	21004					
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Physician /Medical		failure. List only one cause on each line.			Between Onset a					
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	•					
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Division of Vital Records, tall or Attending Physician: The law requiring Information of Manager and I		25. Was case referred to medical 26.Place of Death (Check								
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1010		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltin</li> </ol>	nore. MD 21	223						
	22.7		,							
S Regis	itate strar	31. Date filed (Month, Day, Year) 2012 Registrar's Signature								
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		4a. Facility Name (if not institution			4b. C	ity, Town, or Location	of Death		. County of Death	
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Physician		23a. Part I. Enter the disease, or of failure. List only one cause of		the death. Do no	ot enter the mo	ode or dying, such as c	ardiac or respiratory a	arrest, sno	ock, or neart	Approximate Interval Between Onset and
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		or condition resulting in death)	Due to (or as a conse	equence of):						
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	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence or):						
		(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
OX 68760, The certificate be executed attending physician and over use as the burial - transit	Exa		d							
exectian a	lical	UNPENDED	AMENDED							
60, ate bo	Physician/Med	IF FEMALE:	23c. If yes, outcor	ne of pregnancy				230	d. Date of delivery	
387 rtific ing p	<u>F</u>	23b. Was decedent pregnant in the past 12 months?	I LIVE DITU	2	Fetal de	eath 3 Ectopic	pregnancy		Month D	ay Year
OX (eath ce attend for use	5	1 Yes 2 No 9 Unkr	I ` :=	time of death	Other (	Specify)				
the de	څ		9 Unknown				Los- pid	l tale and a		
ires that the signed by I be detache	D.	Part il. Other significant condition	ons contributing to death	n but not resulting	g in the under	lying cause given in Pa		_		he cause of death?
ires i	ᅙ					_				abiy 4 🗹 Unknown
rds v requi	Completed						24a. Wa	is an opsy		opsy findings available ompletion of cause of
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tal Recions: The certificate ector, page		25. Was case referred to medical	7			26.Place of Death			0 100	2 10
Vita ysicia his cer directa	Be	examiner?	Hospital: 1 Inpatie	nt 2 ER/O	utpatient 3	DOA Other	Nursing Home 5	Reside	nce 6 Other:	Scene
of Ving Phy	P.	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b.	Time of Injury	28c. Injury at Work				
oding th.	悥	1 Natural 5 Pendii	(Month, Day,Y	ear)		1 Yes 2	No			
Signature Atternation of the physical control of the p	g		igation 28e Place of In	iury - At home fa	rm street fac	tory, office building, etc	c 28f Location	(Street a	nd Number or Rus	al Route Number, City
Divi	Certification:	determ	not be	,_,	,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	or Town			
		29a. Certifier 1 Certifying Phy		knowledge de	ath occurred :	t the time date and the	ace and due to the	upo/ol ==	d manner on state	d
To the How within 24 h	Medical	(Check only	ysician: To the best of my inner:On the basis of exar							
To To com	Med	29b. Signature and title of certifier	and manner stated.		- 1	29c. License number			Date signed (Mon	
	-	1				O.C.M.E.			e 29, 2012	, 24,, , our,
18.		my hi				0.0.IVI.L.		Julik	U EU, EU IE	
210		30. Name and address of person v			altima ara O	bent Daltimore &	AD 21222			
J		Ling Li, MD Assistan	nt Medical Examine	900 W. B	aitimore S	ueet, baitimore, N	VIL) 2 1223			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. 1430 Anthony L. Watson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death edidsuca BIGIONAL HICOMICO Cente SA4136414 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 212-86-0769 Director 1 XM 2 □ F 47 Aug 20, 1964 MD Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mantai Hygiene. Is merked other then "netural", or Items 23a or 28e-f show 28e-f shov 10a, State in then "netural", or Items 23a or 28e-f sho the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Eden 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26758 Walnut Tree Rd. 21822 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Paga 1 and 2 should be filt Department of Health and Mantai Importent: If Item 27 Is merked of eny Injury or other treumetic eve ည Lewis N. Harmon Lottie M. Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Watson/wife 26758 Walnut Tree Rd., Eden, MD 21822 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Mem Park 7/9/2012 Salisbury, MD 22. Name and Address of Facility
Lewis N. Watson Funeral Home,
1618 West Rd., Salisbury, MD Signature of Eyneral Service Licenses al 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause ID. Due to (or as a consequence of): anding physicien end use as the burial-transit the Hospital or Attending Physicien: The lew requires thet the death certificate be axecuted Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last ettanding physiclen Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Year signed by the et I be detached fo 1 Yes 2 No g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. seta hes bean signed pege 2 should be der 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy To the Hospital or Attending Physicien: The i within 24 hours after deeth.

To the Funeral Director: After this certificeta i completely filled in by the funeral director, peg 1 ☐ Yes 2 ☑ No Division of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖺 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Matural 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 9179

JUL U 0 2012

31. Date filed (Month, Day, Year)

Clistad CNA

32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STreet Sclishung

7/2/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Irene В. Willing Jul 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HILOMICO 5A6156UL REGIDAR TENINSHIA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours (Month, Day, Year) 214-36-5427 1 - M 2 - F Director 79 07/11/1932 Maryland Usual Residence of Deceden L. 19 IIIIGINGU OUTER THAN "NATURE!", OF Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. ent: If item 27 is marked other than "nature!", or Items 23a or 28a-f sho 10a. State Director 1 Ty Yes 2 No Wicomico Salisbury Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21804 217 Morris Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Anna Mae Long Ralph Wilson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7519 Fire Tower Rd., Hebron, MD 21830 Debra W. Hall/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place WICOMICO MEMOCIAL 20a. Method of Disposition 20c. Location - City or Town, State Date permit, Page 1 a
Department of H
Importent: If ite
any Injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/13/2012 Salisbury, MD Park 21. Signature of Fune a France 2. Name and Address of Facility Holloway Funeral Home Professional Association CFSP Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ Myocard 1111177 Medical resulting in death) Due to (or as a consequence of): Examiner Years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🗙 No 1 Inpatient 2 KER/Outpatient 3 IDOA this After this funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Dending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completely filled in by the f 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

ITC State only one)

31. Date filed

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

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MULGORD

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

JAN 063

STUSBERY

29d. Date signed (Month, Day, Year)

21864

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carol Winters Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wicomico bilitation & Nursing Cto If Under 24 I 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 577-42-2084 **Director** 1 □ M 2**X** F 79 12/17/1932 Washington, DC Usual Residence of Deceder y filed within 72 nouse west.
Ital Hygiene.
ed other than "natural", or items 23a or 28a-f show
e ovent, the Medical Examiner must be notified at. 10b. County 10c. City. Town or Location 10d. Inside City Limits Direct 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 625 Pine Bluff Road 21801 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 🗌 Yes 2 😾 No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic traumatic event, Be 17. Father's Name (First, Middle, Last) permit. Pege 1 and 2 should be filed Department of Health and Mental Hi Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ဂ Douglas winters Dorothy M. Nicholson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Ann Rockelli/Daughter 625 Pine Bluff Rd., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 7/10/2012 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Holloway Funeral Home Professional Association Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner schoole Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and Il-transit resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Win ters Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 9 Unknown signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform 1 Ves 2 N 1 ☐ Yes 2 ☐ No director, or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2V No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate Natural 5 Pending within 24 hours after death.

To the Funerel Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License numb 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print TC Dorodula 31. Date filed (Month, Day, Year) egistrar's Signature 10 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 6, 2012 1930 Рм Claire B. Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Adventist Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min. 579-28-2477 Director 1 🗆 M 2 🖾 F 1923 22, Virginia 89 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at Director 1 X Yes 2 No DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 ms 23a or must be i Funeral 20002 United States 1513 West Virginia Avenue NE "natural", or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Il Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed 6th Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Queen Esther Dunlop Charles Henry Pryor other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 Princeton Lane Waldorf, Maryland 20602 19a. Informant's Name/Relationship (Type, Print) 1105 Princeton Lane Tiffany Daniel - Granddaughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 6, Department of I-Important: If ite any injury or ot once, 1 X Burial 2 Cremation 3 Removal from State Suitland, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility 20019 M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Sepsis with Shock disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Acute Renal Failur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of attending physician and for use as the burial-transit Lactic Acidosis that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached 1 ☐ Yes 2 ☐ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Hunknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an sate has bage 2 s autopsy performed? hours after death. Ineral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 ☐ Yes 2 🙀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 XNatural 5 Pending 1 Yes 2 No Investigation Accident the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe

State Registrar

1500 Forest Glen Road Faizad Malekanian 31. Date filed (Month, Day, 2 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D65729

Silver Spring, Md.

July 7, 2012

20910

amend #5, per fh, g930 8-14-12 SM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amedn #8 per FH g941 7/16/13 TRT State of Maryland / Department of Health and Mental Hygiene per FH TT 7/189artificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ HONSE Medical County of Death Town or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** TON Birthplace (State or Foreign Country) If Under 24 Date of Birth If Under Funeral Hours Min 1/16/1919 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Maryland ms 23a or 28a-f sho must be notified at Director 1 🗆 Yes 2 💢 No 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 20735 permit. Page 1 and 2 should be filed within 72 hours after death with: items ! Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten important: If item 27 is marked other than "hadical Examiner any injury or other traumatic event, the Medical Examiner. Black, White, etc 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 Black 2 No If Yes, Give Year or Dates. 1941-1951 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) 2 RIGHT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) WI 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State heltenha 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Hree 3 nelm rions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on ause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? certificate has blirector, page 2 s 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Hospital ဂ္ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury 5 Pending 1 🔽 Natural 1 🗌 Yes 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò determined filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Expanier: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANNER MO 11701 illian Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

2012

acke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician/ 20 M Doris P. Waldron Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Man 60m 12 MKunA MARHAGIN ADVENDT HUDTING If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace State or Foreign **Funeral** Days Hours (Month, Day, Year) Nov. 8, 1916 317-09-0006 1 □ M 2 🖔 F **Director** 95 Canada Usual Residence of Decedent 28a-f show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director Maryland | Prince George's College Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 4001 Metzerott Road United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ Homemaker own home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other trained. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gustav Pranschke Emma Mentzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4003 Metzerott Road College Park, Maryland 20705 Marlene Young -daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 7/18/2012 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA Nona 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Remo Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnapt 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months' Month Day Year 1 Yes 2 L 9 Unknown the be detached Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Whitnown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag 1 Yes 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes မ 1 Inpatient 2 DER/Outpatient 3 DOA 27, Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 V atural 5 Pending work 1 Yes 2 No Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowled and edition time. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S 30. Name and son who completed cause of death (Item 23a) (Type, Print) 7600 Canal Ne MKCHA 31. Date filed (Month, Day, Year) State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 David W. Zappacosta July 7:15 A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Worcester Berlin 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 D F Months Min 02112 11955 Marviand 219-60-6729 57 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland | Worcester Ocean Pines

10f. Zip Code

1 ☐ Yes 2 K No Specify

(Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

21811

16a. Decedent's Usual Decupation

Financial Manager

12 Was Decedent Ever in LLS

Yes 2 X No

Armed Force

If Yes, Give Year or Dates

College (1-4 or 5+)

10g. Citizen of What Country?

Specify

14. Race - American Indian,

White

Black, White, etc

16b. Kind of Business Industry

Building Supply

USA

18. Mother's Name (First, Middle, Maiden Surname)

Sally Whitelock

Ph\_sician/ Medical Examiner For State Registrar

10a. State

10e. Street and Number

11. Marital Status

35 Harlan Cove

1 Never Married 2 Married

Decedent's Education

(Specify only highest grade completed)

3 Widowed 4 Divorced

Elementary/Seconday (0-12)

17. Father's Name (First, Middle, Last)

Gene R. Zappacosta

Director

Funeral

à

Completed

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 320 state Portugal Land Debatt Arent James Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lawrence Eugene Anderson 08:29A M 87 20/12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Director 577-74-3708 1 🛛 M 2 🗆 F 56 08/11/1955 Washington DC show 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Washington DC DC 10e. Street and Number #302 10g. Citizen of What Country? Funeral 2818 Martin Luther King Jr AveSt USA 20032 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Engineer Private Be 18. Mother's Name (First, Middle, Maiden Surname)
Anna L. Anderson 17. Father's Name (First, Middle, Last) George Raymond Murray 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 4301 W. Village Ave #4017 Camp SpringsMD 20746 19a. Informant's Name/Relationship (Type, Print) Rochelle Grant, daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Beltsville, MD Chesapeake Crematory Harmony Mem. Park Burial 2 XX remation 3 - Removal from State 08/01/12 4 ☐ Donation & ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services e of Funeral Se 4594 Beech Rd. Temple Hills, MD 20748 se of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part 1. Enter the disease shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION Ph\_sician/ ACUTE MYO CARDIAL disease or condition Medical resulting in death) Examiner CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Dav Year Pregnant at time of death g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSILN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC RENAC FAILURE 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy DIABETES performed death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 500 RIE D40324 JULY 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , FILCEP 7600 CARROLL AVENUE, THROMA PITKIR, MARYLHOLD an JODRIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Year Day Physician/ Marian L. Aubertin 1:53 P M July 26 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 904 Neal Drive Montgomery Rockville Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Hours 161-20-1827 Director 1 M 2 X F 85 August 13, 1926 Pennsylvania Usual Residence of Decedent 28a-f shov 10c. City, Town or Location at Director notified 1 X Yes 2 □ No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 ms 23a or must be r Completed by Funeral 904 Neal Drive 20850 United States Health and Mental Hygiene. tem 27 is marked other than "natural", or items: other traumatic event, the Medical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Small Evelyn Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene A. France / Daughter 17542 Longview Lane, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State August 4 ☐ Donation 5 X Other (Specify) Entonbment Gate Of Heaven Cemetery <u> 2012</u> Silver Spring, Maryland 21. Si atur of Fin yice ticensee Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 M01619 300 W. Montgomery Avenue, Rock
Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Interval Between Onset and Death Immediate Cause (Final Physician/ Glioblastoma Multiforme disease or condition resulting in death) 4 months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day 5 Other (specify) Pregnant at time of death ed by the a 1 ∐ Yes 2 ¥ g Unknown ieral Director; After this certificate has been signed by filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 X Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No 24 hours after death. Funeral Director; A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ 3 □ only one)

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 3 0 201

l Bam

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Paul A. Bannen, M.D. 1811 Prince Philip Drive., # 327, Olney, Maryland 20832

29c. License number

D060335

29d. Date signed (Month, Day, Year)

July 27, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg No. 2 1 2 2 4 3						
			Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)		Reg. No. 2. Date of Death 3. Time of Death			
	Physicia Medic		Helen Theresa Butler		July	25 2012	7:45 A M	
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl	1	
	20		Holy Cross Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday,	Silver Spring  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgom	<del></del>	
	Funeral Director		579-46-8789 1 M 2X F 86 Yrs.	Months Days Hours Min.	(Month, Day,	Year) Cou	hplace (State or Foreign intry)	
	MO W		Usual Residence of Decedent		Jan 5	1926   Mar	yland	
	aryland a-f sh	Funeral Director	10a. State   10b. County   10c. City, Town or L   MD   Prince George's	Landover			10d. Inside City Limits 1   Yes 2   No	
	he Ma or 28a e notif		10e. Street and Number	10f. Zip Code		10g. Citizen of What Co		
	with t	eral	7801 Barlow Road Apt #213	20785		USA		
	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene.  The strand Mental Hygiene. The water all the stranger of the transplant of the transplant of the Hygiene and Hygie		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spot 1f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
36		d by	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced  Year or Dates.	1 ☐ Yes 2 🏿 No Specify:		Specify: B1a		
9		lete	15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Business/l	ndustry	
215		Be Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	e kind of work done during most of work DO NOT use retired)	ing	Governmen	nt.	
2			I 2 yrs L	aundry Worker	o (First Middle I			
an		To	17. Father's Name (First, Middle, Last)  James Leonard Butler  18. Mother's Name (First, Middle, Maiden Surname)  Mary Lena Proctor					
ary			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
o` •	and 2 health		the state of the s	.3 Sea Pines Drive	T			
			A Banar 2 - Ordination o - Hemoval nom otate	ematory or other place)	Date	20c. Location - City or Washington ,		
Ë.	permit. Page Department of Important: If any injury or once.			et Cemetery   08/0 22. Name and Address of Facility J. E				
ñ	Der any		▶ Naphney N. Cornelius	7474 Landover Road	, Landov	ver, Maryla	nd 20785	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between	
- 1	h Medical		Immediate Cause (Final disease or condition resulting in death)  a. Severe Sepsis  Due to (or as a consequence of):				Onset and Death	
	Examiner		Alzheimer's Deme	entia				
	- =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			_		
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09/89	ificate ig phy as the	Medi						
9 ×	death certifica ne attending ph ed for use as t	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Live Birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery		•	
Box	s that the gned by the		1 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month Day Year		
P.O.		by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death				the cause of death?	
ds,		ted t	Rhabdomyolysis			1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown		
Records,		Completed	Failure To Thrive			24a. Was an autopsy 24b. Were autopsy findings prior to completion of		
ž			OF Warner of the day		perfor 1 Yes		2 🗆 No	
Vital		To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital:  1 ☑ Inpatient 2 ☐ FB/Outpatient	26. Place of Death (Check	1207-1		6.1	
0			TAL Injurient 2 DEN Outpatient 3 DOA 4 Divising Home 5 Division Home 5 Divisio					
<u>o</u>		Certificate:	1 X Natural 5 ☐ Pending (Wontin, Day, Year) Injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	work? M 1 ☐ Yes 2 ☐ No				
Division of			4 Homicide determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	s, farm, street, factory, office 28		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		ical	29a. Certifier 1 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	the Ho nin 24 the Fu nplete	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				ause(s) and manner stated. s stated.	
	Marth Co.					29d. Date signed (Month) 07/25/2		
			D52503 0772572022					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910								
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Registra	ar	JUL 3 0 2012 June V. Jake					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16 20°12 July 12:45 AM Alzora Childs Bailey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) Director 60 213-54-4134 1 M 2 X F Usual Residence of Deceden 195 Marvland 28a-f shov 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner is ust be extilled at Director 1 Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 2826 E. Madison St. 21205 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes Give Specify: Balck 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 education/human services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ Lillian Thompson Stewart Arthur Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health ( Kester Vincent Bailey - husband 2826 E. Madison St; Baltimore, MD 21205 Department of Health Important: If Item 27 any Injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🗵 Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Licens Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1\Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate Due to for as a consequence of if any leading to immedicause. Enter Underlying Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transif Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physiclan: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 yonths?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 | Yes 2 | 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Dr ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier + crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu d title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore**  Birthplace (State or Foreign Country) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | ULY 11, 1920 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Maryland 92 Director 104-16-3494 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hyglene.
Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Examiner must be notified at Yes 2 No Director MD Baltimore 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number USA 21205 5332 Wright Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∑ Yes 2 [ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify: 2 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dept of Social Services mail sorter unk 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) unk Be Gail Uhler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5337 Wright Avenue; Baltimore, MD 21205 Nancy Weniger - friend other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or oth cemetery, crematory or other place) 1 Burial 2 Cramation 3 Removal from State 4□ Ponation 5 X Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signature Ronald vice License d S. Wade, Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Partyl. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line. Onset and Death Immediate Couse (Final disease or condition dai Physician Due to (\*r as a consequence of): 20 /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed use as the bunal-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 🗌 No detached 9 Unknown the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 No 1 ☐ Yes 2 | No Yes certificate director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 2 💢 No 1 X Inpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 1 Yes P After this completely filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation M 1 Tes 2 No death. 2 Accident within 24 hours after dear To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (check only the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 11595 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

uly 21, 2012

4940 Eastern Avenue, Baltimore, MD, 21224

		,	For State	State of M	arylan					nd Menta	ıl Hygier	ne 🧻	010	01.00
			1. Decedent's Name (First, Middle, Last)  MARGUERITE JO BLACKFORD  2. Date of Death Month JuL 22									No.	UIZ	2403
	Physicia											Day	Year 2012	3. Time of Death
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	and show	5	10a. State 10b. County		10c. City	y, Town or Lo	cation						10	Od. Inside City Limits
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	th wit ms 23 must	ner		reet, NE					20002				u.s	.A.
<b>'</b> 0	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ※ Married	12. Was Decedent 8 Armed Forces? 1 ☐ Yes 2 🗓	Ever in U.S	5.   13. V	Vas Dece f Yes, spe	dent of His	spanic Origin' n, Mexican, P	? (Specify Yes uerto Rican, e	or No- tc.)		ce - America ck, White, e	
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	nd 2 sl salth a n 27 i		Richard Andrew Bl	ackford/Sp	ouse					, Wash				
Baltimore,	e 1 ar i of He if iter or oth		20a. Method of Disposition	Removal from State	20b. P	lace of Dispo emetery, cren	sition (Na	me of other place	9)	Date	20c.	Location	- City or Tov	vn, State
ţ	t. Pag tment tant: ijury o		1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Ft.	Linco	en c	remat	ory 07	7/31/20	12 Br	entw	ood, 1	<i>laryland</i>
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	ee Warh PA	-13	23 2 11	Name a	nd Addres Now H	s of Facility	Hines-1	Rinald	i Fun	reral pring	Home, Inc. MD 20904
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687	rtificat ing ph e as th	101	IF FEMALE:											
Вох	ath certifica attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	Ideath 3		pregnancy	/				te of deliver	
B	t the dea by the a tached t	ysic	1 ☐ Yes 2 █ <b>X</b> No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of d	eath 5∟	Other (s	pecify)				IVIO	onth [	Day Year
P.O.	that the	by Pr	Part II. Other significant conditions of	ontributing to death be	ut not resi	ulting in the u	nderlying	cause give	en in Part I.	236	. Did tobacco	use cont	ribute to the	cause of death?
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>	tal or safte		4 ☐ Homicide determined	building, etc			,	,,			or Town, Sta		or riurar r	loute Number,
	To the Hospital or within 24 hours aft To the Funeral Dir completed filled in	Medical	29a. Certifier 1 X Certifying Physical Check 2 Medical Exami	sician: To the best of a	my knowle	edge, death o	ccured a	the time,	date and plac	ce, and due to	the cause(s)	and manne	er as stated	e(s) and manner stated
	To the P within 24 To the F complet	Me	only one) 3 L Certifying Nurs	se Practioner: To the I	best of my	knowledge, d	eath occu	rred at the	time, date and	d place, and du	ie to the caus	e(s) and ma	anner as stat	ed.
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U			30. Name and address of person who c	ompleted squas of da	ath (Itom	23a) /Tuna D	TAT.		D63995	ΔΤΤΩΝΙΑΙ			4 201 MEDIC	
)			SAIRA N. ASLAM,		au (IICIII	_οα, (1ype, P			A, MD		- PILLI	TUVI	TIBULO	ELL OUNTER
	Stat	ie.	31. Date filed (Month, Day, Year)	32. Registra	r's Signati	ure								<u></u>
	Registra	ar	1111 3 0 2012	/1	· 19	hall								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Physician/ 26<sup>Day</sup> 2012 10:21A M Jacquelyn Beard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Union Bridge 889 Banner Ave. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday, **Funeral** Jun. 26. 1 🗆 M 2 🔀 F Months Hours Year) 1929 Maryland **Director** 215-26-0857 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State **Funeral Director** 1 Yes 2 X No Union Bridge Maryland Carroll 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō must be 23a c 21791 U.S.A. 889 Banner Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Examiner Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. and Mental Hygiene.
Is marked other than "natural", White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) teller/ manager banking 12 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Krise Bruce Houck Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 3443 Blacks Schoolhouse Rd. Taneytown, MD 21787 Debra K. Geisinger/daughter item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State ō 7/31/2012 4 ☐ Donation 5 ☐ Other (Specify) Mt. Union Cemetery nr. Union Bridge, MD 21. Signature of Funeral Service Lic any inj 22. Name and Address of Facility Hartzler Funeral Home, P.A. atharine ( 6 E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical en resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 month 1 Yes 2 No Dav Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performe certificate 1 Yes 2 No Be 25 Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident Suicide Investigation 24 hours after deatl Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier

State Registrar 32. Registrar Signat

Washington Haights Medical Ctr.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,19b per fh g930 8-14-12 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ July 27 2012 9:55pm Robert Veryl Burdette Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Montgomery Hospice Casey House <u>Rockville</u> Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 165-26-4287 **Funeral** (Month, Day, Year) Months Hours 1 ፟M 2 □ F Director Yrs July 10, 1934 Pennsylvania 78 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland of Hyglene, other than "netural", or items 23a or 28a-f sho do when; the Medical Examiner must be notified at, went, the Medical Examiner must be notified at. Director 1 Yes 2 X No Potomac Montgomery Maryland | 10f. Zip Code 10g. Citizen of What Country? Funeral 11708 Beekman Place 20854 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No If Yes, Give 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 X Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: White 3 Divorced Year or Dates. 1957–1959 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Flementary/Secondary (0-12) New Home Construction 4 Builder other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t, Page 1 and 2 should be filex tment of Health and Mental H tant: If Item 27 Is marked ot 2 Grace Rapp Forbes W. Burdette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 19a. Informant's Name/Relationship (Type, Print) 4520 Minuteman Drive, Rockville, Maryland Laura Burdette Mechak/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) of Heaven Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
eny Injury or ot 1 Burial 2 Cremation 3 Removal from State August 3, 2012 Silver Spring, Maryland Robert A. Pumphrey Funeral Home/ 300 West Montgomery Avenue and 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rob-Rockville, Inc. 300 Rockville, Maryland 21. Signature of Funeral Service Licenses M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examir attending physician and if for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day 1 Yes 2 No been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2 K N this certificate hes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 ☐ Yes 2 🔯 No 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at After (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident 5 Pending м death. n 24 hours after death.

Funeral Director: Ailetely filled in by the fu Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Debrah Miller CRNP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 07 19 2012 5:45A Jesse Bibbens Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore Overlea Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 0 0 4 7 1 9 4 2 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday Maryland **Funeral** Months Days Hours 1 X M 2 □ F 214-44-7267 69 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Experient must be notified at 1 √Yes 2 No Director Baltimore N/AMD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21218 1521 Kingsway Rd. Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 □xdever Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Sinai Dietary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi Lula Munson Jesse Bibbens ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 1521 Kingsway Rd., Baltimore, MD 21218 Pages 1 and 2 s ment of Health an William Bibbens (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If Ite any Injury or ot 7-20-12 1 ☐ Burial 🏖 Cremation 3 ☐ Removal from State Baltimore, MD on-site Creamtory 4 ☐ Donation 5 ☐ Other (Specify) 270384714dr Srown Jr. Funeral Home PA 21. Sonatur∋ of Funeral Service License Baltimore, MD 21217 2140 N.Fulton Ave., Ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hort failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical ince of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the up Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 2 No 1 ☐ Yes director, 26. Place of Death (Check only of Be 25. Was case referred to medical examiner? Other: Hospital: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To After this 27. Manner of Death 1 Natural 2 Accident 3 Suicide 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation n 24 hours after death.

e Funeral Director: Af illetely filled in by the fur 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Blud, Ballinore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	/larylan	-	artment of F		nd Me	ental Hy	giene		0 0	-016
			1 = State Registrar  1. Decedent's Name (First, Mid.	Idle Last)		Cei	tificate of L	Death			Reg. No.	20	2 2	4046
	Physicia Medic		Cerroll W	). Builer						2. Date of Dea	2 Day	20 Yea		of Death
	Examin	er	4a. Facility Name (if not instituti	.1	1		4b. City, Town, or	\		,	4c. (	County of D	eath	
E	Funeral		5. Social Security Number			ast birthday)	If Under 1 Year	If Under 24	4 Hrs.	3. Date of Birt	h		Birthplace (State	e or Foreign
	Director		219-80-1174	1 💢 M 2 🗆 F	45	Yrs.	Months Days	Hours	Min.	(Month, Da)	, Year) <b>/19</b> 6		<sup>Country)</sup> arylan	
	od now at	Ļ	Usual Residence of Decedent 10a. State 10b. Coun			y, Town or Lo	cation				,		10d. Inside	
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	with s 23a ust b	Funeral Director	2956 Cherry	yland Rd.				212	225	İ		U.S	.A.	
	death items ner m		11. Marital Status	12. Was Decedent Armed Forces	7		Vas Decedent of Hi f Yes, specify Cuba	spanic Origir n, Mexican, F	n? (Specif Puerto Ri	fy Yes or No- can, etc.)	1	4. Race - A Black, W	merican Indian,	
36	after al", or xami	d by	1 Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorc	If Voc. Circo	<b>N</b> o		☐ Yes 2x No	Specify:			s	pecify:	Black	
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21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12	ghest grade completed)  2) College (1-4 or	5+)	life. D	kind of work done on NOT use retired)				- 7	_		
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ary	hould and Mar s mar umati		19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailir	ng Address (Street a	and Number	or Rural F	Route Numbe	r, City or T	own, State,	Zip Code)	
	and 2 s Health s tem 27 i		Sheila Gibs	on(sister)		2956	Cherryl	and F	Rd.,	Balt	imor	ce, M	ID 2122	25
Baltimore,			20a. Method of Disposition 1 Durial 2 Crematic	on 3  Removal from Stat	_ 0	emetery, crer	sition (Name of natory or other plac	e) .7	Da:			-	or Town, State	
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			23a Part 1. Enter the disease, enock, or hear failure. Lis	or complications that cause st only one cause on each li	ed the deat	h. Do not ente	er the mode of dyin	g, such as ca	ardiac or r	espiratory arr	est,		Approxim Interval B	letween
	Medical												Onset and	d Death
$\vdash$	Examiner		resulting in deathy	Due to (or as	s a consequ		ancei						Im	-
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	ate be executed ohysician and the burial-transit	alE	resulting in death) Last	Due to (or as	s a consequ	uence of):								
200	cate b physia s the b	edical		d										
687	certifi nding use a	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregna	incy	16				2	3d. Date of	delivery	
Вох	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant 9 Unknown	at time of o		Ectopic pregnand Other (specify)	У				Month	Day	Year
P.O.	hat the death certific ed by the attending p detached for use as		9 Unknown Part Jl. Other significant condi			sulting in the u	nderlying cause giv	en in Part I		23a Did to	bacco us	e contribute	e to the cause of	f death?
S, D	signed b	Completed by		mmunode		-	Viru	2		1 🗆	•		Probably 4	
ord	require been si should	lete				- 1				24a. Was a	an	24b. Were	autopsy finding	s available
3ec	The law ate has page 2 s	omb									rmed?	death	to completion of 1? Yes 2  No	f cause of
la	ysician: The s certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Pla	ace of Death	(Check o	1 ∐ Yes nly one)	2 110		163 2 1140	
Š	Physic this ce al dire	은	1 ☐ Yes 2 💢 Vo			ER/Outpatier		4 □ Nurs	sing Home	e 5 🗆 Resid	lence 6	Other (Sp	ecify)	
n of	ding P. h. After t funera	ate:	27. Manner of Death  1 Natural 5 Pend			28b. Time of injury	28c. Injury work		- 1	d. Describe h	ow injury	occurred		
Division of Vital Records,	or Attendi after death Director: A I in by the f	Certificate:	3 Suicide 6 Cou	28e. Place of In	ijury - At ho	ome, farm, stre	eet, factory, office	ies Z L N	_	f. Location (S	treet and	Number or	Rural Route Nur	mber,
Divi	tal or A rs after al Direct led in by		4 - Homicide dete	building, e	tc. (Specify	")				City or Tow	n, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 124 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical	(Check 2 \(\sum \) Medica	ing Physician: To the best of al Examiner: On the basis of ing Nurse Practitioner: To t	examination	n and/or invest	igation, in my opinic	n, death occu	urred at th	e time, date a	nd place, a	and due to the	ne cause(s) and r	manner stated.
	To the within To the Comp	2	29b. Signature and title of certif				29c. License		ara piase				nth, Day, Year)	
			Khey-F	I'm tus	)		03	59166	00		Jul	123,	51GS	
			30. Name and address of person	on who completed cause of	death (Item	23a) (Type, F	Print)	Lin	وين	TAAL		フュフ	20	
	Stat	te	31. Date filed (Month, Day, Year	32. Regist	ryr's Signa	fure /	1. 100	CIEVAD	200	VVVI		016		
	Registra	ar	JUL 3 0 2012	- Leneur F	1. 19	w								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 1<sup>2</sup>9<sup>3</sup> 20°1°2 1:00 Ам James Edward Codd Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 719 Maiden Choide Lane; HR419 Baltimore Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year **Funeral** Days 1**X** M 2 □ F 89 Hours 216-18-9032 Director 1923 Maryland pril Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🗆 Yes 2🔽 No Baltimore MD Catonsville ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23 719 Maiden Choice Lane HR419 21228 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1X Yes 2 No 1943If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Š 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed 1945 Year or Dates 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 financial accountant Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Ann Duke James Edward Codd Sr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Lane HR419; Catonsville, MD 2122 Anne Codd - wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Si mai in of Funeral Savid 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Due to on a consequence of: disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or I that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person

3 0 2012

d cause of death (Item 23a) (Type, Print)

D30989

711 Maiden Choice Ln

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Chase 07779/20982 Physician/ Rose 06:21 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Clinton** 4c. County of Death
Prince Georges Examiner Southern Maryland Hospital Social Security Number Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 216-40-8730 69 Director 1 🗆 M 2 🔀 F 04/10/1943 Maryland or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Maryland Funeral Director Clinton Prince Georges 1 ☐ Yes 2X No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or ms 23a or must be r 9211 Stuart Lane 20735 USA or items death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. þ 1 Never Married 2 X Married and 2 should be filed within 72 hours after of Health and Mental Hygiene. tem 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed Year or Dates er than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Nurse Calvert County Gov. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Walter Jackson Merlissa Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rhea Jackson, daughter 3717 Donnell Drive Forestville, MD 20747 tem 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Page 1 Department of Important: If it Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Hope UM Church 07/28/12 Sunderland, MD 4 Donation 5 Other (Specify) 21. Signature of Fyneral Service 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Rd. Temple Hills, MD20748 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List Immediate Cause (Final disease or condition Prysician/ Medical resulting in death) **Examiner** Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy in the past 12 month for Month 5 Other (specify) Yes 2 No ed by the a detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 🗌 Yes 2 🗌 No this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ္ဝ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Pfactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 2012 cause of death (Item 23a) (Type, Print) 30. Name and address completed State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Geraldine Elizabeth Clark Month Jul 25, 2012 Year 1:20 AM Physician/ Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Catonsville 716 Meadowbrook Ave. **Baltimore** 8. Date of Birth **2/2/1941** (Month, Day, Year) **Jun 2**, 1941 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs, last birthday **Funeral** Min. 1 🗆 M 2 🗙 F Months Days Hours 220-36-7508 71 Director Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10b. County 10a. State 10c. City, Town or Location Director **Baltimore** Catonsville MD 1 Tes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Funeral 716 Meadowbrook Ave. 21228 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11 Marital Status Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates. 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Bookeeper Clerical Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Mary Carr James Washington Hawk မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1906 Windys Run Rd. Catonsville, MD 21228 19a. Informant's Name/Relationship (Type, Print)

Mary T. Martin Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jul 27, 2012 Crest Lawn Memorial Gardens Marriottsville, Maryland 22. Name Stack Fune Fail Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Approximate Interval Between n t and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) mo Medical Due to (or as a / nsequence of) **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of). in any, leading to immediate cause. Enter Underlying sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year Pregnant at time of death 5 Other (specify) this certificate has been signed by the ral director, page 2 should be detached 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant co**nd**itions** contributing to death but not resulting in the underlying cause given in Part I. by 1 XYes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical å examiner? Other: 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number \( \) 38762 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5 haron Me Cornock MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Rd - Suite

DHMH 17 Rev 7/2009

State

Registrar

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31. Date filed (Month, Day, Year)

parked

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Josephine Coruzzi 9:55 July 24, P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Manor Care Potomac Montgomery Potomac Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min. (Month, Day, Year) 097-01-4995 Director 1 M 2 X F 98 Yrs. July 20. 1914 Connecticut Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City. Town or Location Director 1 Yes 2 X No Maryland | Montgomery Potomac r items 23a or iner must be n 10e. Street and Number 10f. Zip Code 'n 10a. Citizen of What Country? Funeral 10714 Potomac Tennis Lane #222 20854 United States filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Hairdresser Cosmetologist traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ Girolimo Bressan Assunta Periboni 1 and 2 should be Health and Meinten 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Coruzzi Wise / Daughter 4260 Halibut Point Road, Sitka, Alaska 99835 20b. Place of Disposition (Name of Montgomery crematory or other place) Crematorium, Inc. 20a. Method of Disposition Date 30, 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Si nature of Figural Sey con Ligensee Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Debility disease or condition years Medical resulting in death) Due to (or as a consequence of): Examiner Advanced Atherosclerosis years Sequentially list conditions. in any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence on: that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Box 68760 as the l attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy ō in the past 12 Day Pregnant at time of death 5 Other (specify) Month Year Yes 2 X No signed by the a 1 ☐ Yes 2 ₽ 9 ☐ Unknown a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Dementia 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s this certificate has autopsy Hospital or Attending Physician: The 124 hours after death. Funeral Director: After this certificate h performe death? 1 ☐ Yes 2 X No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 🗓 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  $4\,\mathrm{K}$  Nursing Home  $5\,\square$  Residence  $6\,\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural Accident 5 Pending work? 1 🔲 Yes 2 🔲 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of 29d. Date signed (Month, Day, Year) D31319 July 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loreto S. Albiol, M.D. 8218 Wisconsin Avenue #305, Bethesda, Maryland 20814

ORIGINAL

2. Registrar's Signature

31. Date filed (Month, Day, Year)

State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:25 PM aVIS Month -2 Day Physician/ Ichae 2092 2 Vom2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Loch Raven Community Living Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 XM 2 □ F 0 2 Month 1 Day, Months Days Hours Min. Country) 220-64-8488 DC **Director** 56 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland sartment of Health and Mental Hygiene. Sortant: If item 27 is marked other than "natural", or items 23a or 28a-f shorinjury or other traumatic event, the Medical Examiner must be notified at 10a. State Director and Mantal Hygiene. is marked other than "natural", or items 23a or 28a-f s raumatic event, the Medical Examiner must be notified 1 Yes 2 No Baltimore MD NA 10f. Zip Code 21215 10e. Street and Number 10g. Citizen of What Country? Funeral 3806 Dorchester Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗎 Divorced Completed Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) 12th grade (0-12) College (1-4 or 5+) Home Improvement Carpentry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Telious Levander Davis Elizbeth Thompson Doris 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code), 8428 Polo Pointe, North Charleston, SC 29418 19a. Informant's Name/Relationship (Type, Print) Stacey Belton-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Garrison Forest Vet 7/30/2012 Owings Mills, Donation 5 Other (Specify) MaNegand 如今野。Wellst 4300 Wabash Ave, Baltimore, Md 21215 21. Sig tule of Funeral Service License 23a. Par 1. Enter the Lisease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirth, or heart dilure. List only one cause on each line. Approximate interval Between Onset and Death ancer Immediate Cause (Final disease or condition Sophagea .Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** 20 atitic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 2 1 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Tes 2 No Accident
Suicide Investigation Could not be To the Funeral Director: completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 041365 \_0 3900 30. Name and address of person who completed cause of death (Item 20a) (Type, Print) och E Jeorge 31. Date filed (Month, Day, Year)

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 21<sup>y</sup> July 201°2 9:05 PM Joe Calvin Dawkins Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital 5. Social Security Numberunk 6. Sex If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 70 **Director** 1 🗶 M 2 🗆 F Yrs 1942 Bouth Carolina Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a. State notified at Director Washingtoh 1 Yes 2X No DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ritems 23a or ner must be n USA Funeral 20010 6212 Georgia Avenue NW 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian er than "natural", or ite the Medical Examiner Armed Forces? 1 X Never Married 2 Married þ within 72 hours after **Black** 1 ☐ Yes 2 X No Specify: If Yes, Give Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) unk Elementary/Secondary (0-12) church custodian unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H 2 Jean Dawkins Haskel Dawkins permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Illinois Circle; South Carolina 29341 Juanita Dewberry - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in State 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service licenses Nade 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or least failure. List only one cause on each line. Interval Between Onset and Death WEARLTOW Immediate Cause (Final Physician/ MYOCARDIAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ASTMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-trans Due to (or as a consequence of): Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 hor To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 [ 3 ] only one) 29b. Sig and title of ce 29d. Date signed (Month, Day, Year) 2012

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of o

3 0 2012

Randall P. Wagner

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

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Records,

of Vital

Division

Washington Adventist Hospital Takoma Park ,MD 20912

ath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27<sup>ay</sup> Physician/ July 2012 3:15 P Dayhoff Gary Truman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Keymar 12637 Keymar Rd. 8. Date of Birth Mar. 27, 1936 Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Min. 1 **X** M 2 □ F Months Hours Mary land 76 Director 218-32-5416 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 Yes 2X No Keymar Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 21757 U.S.A. 12637 Keymar Rd. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force 9 1 Never Married 2 X Married 2**X** No þ ☐ Yes permit. Page 1 and 2 should be filed within 72 hours after v Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry car/truck Elementary/Seconday (0-12) College (1-4 or 5+) truck mechanic dealership 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thelma Johnson Truman Dayhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keymar, MD 21757 Shirley A. Dayhoff/ wife 12637 Keymar Rd. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State 8/6/2012 Sykesville, MD 4 Donation 5 Other (Specify) All County Cremation 21. Signature / Formeral Service Licen 22. Name and Address of Facility Hartzler Funeral Home, P.A. affarine Windsor, MD 21776 P.O. Box 249 New 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Non-Hodgkin's lymphoma yrs. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 2 months B-cell lymphoma of the brain Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of, Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending properties for use as use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 No Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hereditary coproporphyria cate has t autopsy performed? 1 Yes 2 K No certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours af er dea h. Funeral Director: After this eted filled in by the funeral di 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural Accident Suicide 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

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completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 54 8 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28 112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD 21701 300 W. 9th\_St. Martha Pierce 31. Date filed (Month, Day, Year, 32. Registrar's Signatur State 3 0 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July 30° 2012 Helen Marie Farver 4:29 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice-Dove House Westminster 8. Date of Birth (Month, Day, Year) March 29,1929 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 218-24-9780 Mary Land Director 1 M 2 XXF 83 Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director Carroll Mt. Airy 1 Yes 2XXNo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4703 Ridge Road 21771 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc. ò 1 Never Married 2 X Married ۵ Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: 3 🗌 Widowed 4 🗌 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) 12th Own Home Housewife Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert P. Devilbiss Marie Agnes Nickoles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1602 Terrace Drive Westminster, MD 21157 Robert Farver son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Lake View Mem. Park 20a. Method of Disposition 1 😾 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗋 Donation 5 🗆 Other (Specify) Aug. 2, 2012 Sykesville, MD 21. Signature of Funeral Service 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 23a. Lart 1. Inter the disase, or complications shock, or heart failure. List only one cau hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Im nediate Cause (Final di asser condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to in media cause. Enter Underlying Dise to for as a nonsequence off Examin Hospital or Attending Physician: The law requires that the death certificete be executed Cause (Disease or injury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 7 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 1No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur ompleted cause of death (Item 23a) (Type, Print) vestminste 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ZOIZ Physician/ Medical 4 55 PM ores 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death Examiner MONTGOME BUZTENS VI LL at W055 9. Birthplace 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 713 1 🗆 M 2 😿 F **Director** 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director 1 Yes 2 No WASHINGTON DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20019 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 1 🗌 Yes 2 🗙 No Baltimore, Maryland 21215-0036 BLACK Specify 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GERIATRIC Be 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) DIVES WALTER 2 MILDRED 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20 BURNS STNE 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State WALDORF 3 MD HERLITAGE HEH COM 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 20011 UPShew M0125 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stro Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** er tension Sequentially list conditions. Examiner Due to as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death ed by the a detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Icidney disease 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completely filled in by the funer 1 Natural 5 - Pending iniury Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature 53337 Name and address of person who completed cause death (Item 23a) (Type, Print) 34 Road 3 0 2012 2. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

State

Registrar

3 0 2012

Please Type or Print in Black/Indelible Ink. Ensure All Copies Are Legible. amend #205 Per FH G929 / 30/2012 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Montl Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner MOM Date of Birth (Morth, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Months 371-60-6487 52 1 💢 M 2 🗆 F Director Yrs Michigan Feb. 22,1960 ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Fort Myers Lee Florida 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be gince. Funeral 11301 Longwater Chase Court U.S.A. 33908 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Ophthamology Medical Doctor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Frieda Ginsburg Jack Glasser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11301 Longwater Chase Court, Fort Myers, Florida 33908 Susan Glasser: Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 07/30/2012 X Burial 2 Cremation 3 Removal from State Naples, Florida Naples Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, F.A. Signature of Funeral Service Licensee 6009 Harford Road, Baltimore, Maryland 21214 Approximate Interval Between Onset and Death 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Brain Tumor Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of): Physician/Medical Examine Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: attending yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy nerformed? 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 은 within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5  $\square$  Pending Investigation Accident 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗔 29d. Date signed (Month, Day, Year) 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 Unleans Street Bultimore ManyLand 21287 SRIKRISHNA

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:06 AM Homer Washington Gillis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospice Birthplace (State or Foreign Country) If Under Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours 137-14-4633 Director 1 X M 2 🗆 F 91 01/13/1921 Maryland or 28a-f show f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location Director Silver Spring 1 ☐ Yes 2 💢 No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. and 2 should be filed within 72 hours after death with 20904 3148 Gracefield Road, #CL523 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black 3 Widowed 4 Divorced WWII Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) Housing Urban life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Development 5+ Executive Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Fannie Waters Fredrick Cornelius Gillis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4408 Huntchase Drive., Bowie, Maryland 20720 Betty Gillis-Robinson - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or oth 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 08/02/2012 | Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. . Signature of Funeral Service Licensee 1232 | 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ umonia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Exami Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Veal 5 Other (specify) Pregnant at time of death been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at injury 5 Pending 1 Natural work?
1 Yes 2 No s after death. Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ģ 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier The full state of the pass of the pass of the pass of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 25 2012 umana oulen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 GRACEFIELDRUAD, SILVERSPRING, MD 20904 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month . 7 Physician/ Day Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice Harwood Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days Hours Min 582-52-8205 Director 1 □ M 2 □ F 75 02/24/1937 Puerto Rico Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Anne Arundel Maryland Severn 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1836 Montreal Road 21144 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2XX Married 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 tXXYes 2□No Specify: Puerto Rican 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Heavy Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Sumame) Celestina Gonzalez of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Page 1 and 2 s Olga A. Gonzalez 1836 Montreal Road Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any Injury or o ਰ ਵ Creffat 1617 Centler lace) of Maryland 1 Burial 2XXCremation 3 Removal from State 07/23/12 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, F.A. michael 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 007 MPHOMA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 🗌 No 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospics Certificate: To 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Z D003658 25 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $J_{uly}^{Month}$ Physician/ 2012 June Louise Galuardi 28 1:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 205-22-1506 Director 83 Dec. 22, 1928 Pennsylvania Usual Residence of Decedent if Hygiene. I other than "natural", or items 23e or 28a-f shov vent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 11505 Bedfordshire Avenue 20854 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic even pe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke eny Injury or other traumatic Smith Huston Christina Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Galuardi/Husband 11505 Bedfordshire Avenue, Potomac, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State August Montgomery Crematorium Bethesda, Maryland 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licensa Robert A. Fumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 Willa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Multilobar Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying that the death certificate be executed use as the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 igned by the attending be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Dunknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy After this certificate Yes 2 🕅 N director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) FiGSpice 1 ☐ Yes 2 🗓 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funerel Director: A ☐ Accident the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a Certifier To the Hosp within 24 hou To the Fune completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Decrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month. Day, Year) R143201 7.28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) 82. Registrar's Signature State 3 0 201 Registrar

Registrar

DHMH 17 Rev 1/2001 11595

State

egistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4-31298

29,2012

JOLY

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10c Per FH G929 7/30/2012 JH. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ June Thomas P. Howard Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Severna Park 478 Fair Oak Drive Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Davs Hours Min (Month, Day, Year) 205-20-0107 84 **Director** 1 **X** M 2 □ F Nov 19, 1927 Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10b. County 10c. City. Town or Location 10a. State Director Severna Park 1 Yes 2 X No Anne Arundel MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21146 478 Fair Oak Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? 1 Yes 2 No 1946-Black, White, etc. 0 1 Never Married 2 X Married þ within 72 hours after 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: white "natural", 3 Widowed 4 Divorced 1947 Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. is marked other than College (1-4 or 5+) Dept of Agriculture other traumatic event, the human resources rep Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental fitem 27 is marked 2 Margaret Mary Hayes Thomas Patrick Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 478 Fair Oak Dr; Severna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) Margaret Howard - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Ronald S Wade 655 w. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine as the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy been signed by the atter should be detached for in the past 12 months? Day Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No NONR 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy Yes 2 After this certifications funeral director, I To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manyer of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Investigation Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) ture and title of certifier 20

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day, Year,

eted cause of death (Item 23a) (Type, Print)

Registrar's Signature

ANNOPOLO

Val/8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy Hinkson Ju<sub>1</sub>y 2012 9:05  $A^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil Abbey Manor Assisted Living Facility E1kton If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Yea March 31, Months Hours Min. Year **Director** 220-22-0174
Usual Residence of Decedent 1 DM 2 X F 90 1922 Maryland ms 23a or 28a-f show must be notified at Oa. State 10h County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Tes 2 X No MD Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21903 1701 Perryville Road ral", or items a 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 Yes 2 No or. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: white If Yes. Give "natural" Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within Hygiene.

'the than "the Mexical Street (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) accountant financial event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental ပ Howard David Neff Frances Elizabeth Kessey 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 1701 Perryville Rd; Perryville, MD 21921 S f Health a Sandra M. Anderson - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Department of Important: If any injury or 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Full ral Sprice L Ronald S Director 655 W. Baltimore St; Baltimore, MD 21201 600 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or): Cause (Disease or injury tran that initiated events resulting in death) Last Due to (or as a consequence of): as the burial the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Year 1 Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 Yes 2 No 3 Probably Completed page 2 should peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law this certificate has 1 Yes 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Tyes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Nursing Home 5 ☐ Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After ▲ Natural (Month, Day, Year) 5 Pending Investigation
6 Could not be 1 🗌 Yes 2 🗌 No within 24 hours after death To the Funeral Director: Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar 29a. Cortifi

only one) Signature and title of

🔊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 25<sup>Day</sup> 2012 Agnes Hastings 2:30 P M Jane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Buckingham's Choice Adamstown Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** January 17,1936 New York Director 112-28-7601 1 □ M 2 🗓 F 76 permit. Page 1 and 2 should be lited whithin the control of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 - Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2116 Dixon Drive 21704 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Romano Al exander Pfeifle 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cary Plamondon 2116 Dixon Drive, Frederick, Maryland 21704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Sepulchre Cemetery 7-30-12 Coram, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. hal 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) neumoma Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ **To the Funeral Director:** After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for i in the past 12 months? Day Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 2 🕅 No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) Do058726 7-27-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Md 21773 Myers ille 3000-D Ventrie vette Warren MO 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Box 68760

Division of Vital Records.

12-05609 Harry Hampton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 24061 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 27, 2012 Modical Examiner Harry Hampton 1607 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1600 Hardwick Court # 404 Anne Arundel 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director May 1,1935 Country) Wyoming 1 X M 2 F 520-32-4612 77 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once, 1 Yes 2 X No Maryland Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.

ant. If litem 77 is marked other than "natural", or items 23a or 28a-f sho rother trawn atic event, the Medical Examiner must be notified at once. Anne Arundel Hanover Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Hardwick Court #404 21076 U.S.A. Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status White, etc. Armed Forces? 1 X Never Married 2 Married 2 White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify: <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Military Personnel U.S. Army 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jasper James Hampton Ella Fern Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ္ 2664 Lake Pointe Drive, Cookeville, Tennessee 38506 Linda Emerson : Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 7-30-12 Baltimo permit. Page: Department o Important: injury or oth Hanover, Maryland Donation 5 Other Specify. <u> CremationCenterOfMarv</u> 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last The law requires that the death certificate be executed Physician/Medical **AMENDED** UNPENDED attending physician or use as the burial of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Diabetes Mellitus, Obesity, Heart Failure Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? 1 🗸 Yes ✔ Yes 2 No 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical director, Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA this 1 Yes ٩ 28c, Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 1 🗸 Natural Division 1 Yes 2 No Pending within 24 hours after death. To the Funeral Director: the 2 \_\_\_ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of of 14 pm July 28, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) OCME Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Mary

31. Date filed (Month, D 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

**ORIGINAL** 

12-05559 Melvona N Jackson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 24062

		1-For State Registrar Certificate of		Reg.	No.	
Physic		Decedent's Name (First, Middle,Last)		Date of Death     Month     Date	ay Year	3. Time of Death
edical Exam	ıner	Melvona N. Jackson Melvina T. Ja  4a. Facility Name (if not institution, give street and number)	ackson  b. City, Town, or Location of Dec	July 25, 2012	2 4c. County of Death	1405 hrs
		4512 White Oak Ave	Baltimore		To county of bodg	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24		MM/DD/YYYY) 9. Birt	hplace (State or
Director		218-05-3615 1 M 2 NF 96 Yrs.	Months Days Hours M	May 11,	1916 Co	n <sub>untry)</sub> Georgia
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
		MD Baltimore				1 X Yes 2 No
Aaryland 28a-f show I at once	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
15-0036 filed within 72 hours after death with the Maryland I Hygiene. d other than "matural", or items 23a or 28a-f sho t, the Me tical Examiner must be ootified at once.	Dir	4512 White Oak Ave.	21215		USA	
th with	Funeral		s Decedent of Hispanic Origin? (		14. Race - Americ	can Indian, Black,
er dea		Tes 2 X No	Yes 2 X No specify:		Specify: B1	ack
rurs afi Itural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	's Usual Occupation (Give kind o		open,	
6 172 hc an "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use r		Dept of	
5-003 led withir Hygiene. other the	gmo	12 0 Income  17. Father's Name (First, Middle, Last) unk	Maintenance A	dm • me (First, Middle, Maid	Services	
e, MD 21215-0036  I and 2 should be filed within 72  Health and Mental Hygiene  'item 27 is marked other than "  rtraumatic eveot, the Me licel.	Be C	George Thornton		Thornton	den Surname)	
2121 tould be fi d Mental I is marked	ToE	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing	Address (Street and Number of			Zip Code)
and 2 sh lealth an tem 27 i		,	Shipway; Dundal		22 0c. Location - City or	Town Chata
- s 4 = 2		1 X Burial 2 Cremation 3 Removal from State crematory or oth	er place)	Date	oc. Location - City of	Town, State
Baltimo permit. Page Department o Important: injury or ott		4 Donation 5 Service Licenses Arbutus Me 21 Signature of Funeral Service Licenses / 22 No	emorial 8-	4-12 A	rbutus, M	d.
Ba perm Depi		21 Signature of Funeral Service Licensed Ronald Swade, Director 430				21201 21215
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardio	ovascular Disease			Death
j e		b				
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		-		
ıt.	Examine	(Disease or injury that initiated events resulting in death) Last   C. Due to (or as a consequence of):			•	
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit		d. UNPENDED X AMENDED 1, per me, 16a	17 202-2 22 2	or fb ~020	9 7 12 ***	12
50, te be ex sysiciar burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	12
ox 687(eath certifica eath certifica eathending ph	an/N	23b. Was decedent pregnant in the nast 12 months?	al death 3 Ectopic preg			ay Year
Sox (leath co	Physician/	4 Pregnant at time of death 5 Oth 1 Yes 2 ✔ No 9 Unknown 9 Unknown	er (Specify)			
O. B. It the de I by the		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
cords, P.O law requires that: has been signed b	d by	Dementia		1 Yes 2	No 3 Prob	ably 4 🗸 Unknown
tal Records  cian: The law requ  certificate has been	Completed			24a. Was an autopsy		opsy findings available ompletion of cause of
Reco	omi			performed 1 Yes 2 ✓		s 2 No
ician: ician: s certifi rector.	Be	25. Was case referred to medical examiner? Hospital: 1 Innertical 3 EB/Outcations	26.Place of Death (Chec			
n of Vital ding Physician: h. After this certif	ဦ	1 ✓ Yes 2 No		sing Home 5 Res	injury occurred	Scene
ion of tending Pheath.	tion	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No		,,	
by ect	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	t, factory, office building, etc.	28f. Location (Stree or Town, State		al Route Number, City
Divi	Cert	4 Homicide determined (Specify)		or rown, state	···	
To the Hospital within 24 hours To the Funeral completely filled	ical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurre (check only one)  2 Medical Examiner: On the basis of examination and/or investigation.				
To th To th	Medical	and manner stated,  29b. Signature and title of certifier	29c. License number		d. Date signed (Mon	
$\langle n \rangle$		Parate Rindhall, MD	O.C.M.E.	Ji	uly 26, 2012	
(3)		30. Name and address of person who completed cause of death (Item 23a)				
		Pamela E. Southall, MD Assistant Medical Examiner 900		timore, MD 2122	?3 <del></del>	
S: Regis	tate	31. Date filed y muth 3a (Yea) 12 32. Registrar's Signature				

#### Please Type or Print in Black indelible Ink. Ensure All Copies Are Legible.

2012 24063 State of Maryland / Department of Health and Mental Hygiene Lance Johnson 1- For State Certificate of Death Registrar 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Medical Month Day July 5, 2012 0147 hrs Examiner Lance Johnson c. County of Death 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Deeth 2343 North Eutaw Place 1st Floor 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5 Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Country Months Devs Hours 215-96-2052 Director 40 02/22/1972 1 M 2 F New York Usual Residence of Decedent 10d. Inside City Limits 10h Counts 10c City, Town or Locetion 10a State 1 Yes 2 No 23a or 28a-f show notified at once. N/A Baltimore death with the Maryland 10g. Citizen of Whet Country? 10e, Street and Number U.S.A. 2343 Eutaw St. 21217 ō Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Rece - American Indian, Black, 11 Merital Status 12. Wes Decedent Ever in U.S. Pages 1 and 2 should be filed within 72 hours after death wil anet of Ffeallh and Mental IFygiene anet II tiem 27 is marked other than "natural", or items; or other trannatic event, the Medical Examiner must be; Armed Forces If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 X No 1 Yes 2 X No specify: Specify Black 4 Divorced If Yes, Give Year Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mortgage Lender Baltimore, MD 21215-0036 Telemarketer 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17 Fether's Name (First, Middle, Last) Harry B. Johnson Rolonda Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print ) Baltimore, MD 904 Reverdy Rd., Wanda Watters(friend) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place. 1 K Burial 2 Cremation 3 Removal from State 07/13/12 Woodlawn Cem Baltimore, MD Important: injury or oth 4 Denstion 5 Other Specify Signature of Funeral Service License <sup>22\_Name and Address of Facility</sup> Joseph H Brown Jr. Funeral Home PA 2140 Ñ. Fulton Ave., Baltimore, ac Approximate Interval e disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert Part I. Enter the disease, or complication failure. List only one cause on each line **Physician** Between Onset and /Medical Death Immediate Cause (Final disease Multiple Gunshot Wounds Examiner or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions Due to (or es a consequence of) if any, leeding to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initieted Due to (or as a consequence of) events resulting in death) Last and tra Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the bunal The law requires that the death certificate be Box 68760 23d Date of delivery 23c. If ves, outcome of pregnancy 23b Wes decedent pregnant in the 3 Ectopic pregnency Dev Year 1 Live birth Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 X No 3 Probably 4 Unknown Completed Division of Vital Records, has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of performed?

| X Yes 2 No death? 1 X Yes 2 No certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 X Other. Scene 1 Inpatient 2 ER/Outpatient 3 DOA this 1 X Yes P 28a. Date of Injury FOUND: 28d. Describe how injury occurred 28c. Injury et Work? After Manner of Death 28b Time of Injury Certification: Subject shot FOUND: within 24 hours after common To the Funeral Director: A 1 Natural 1 Yes 2 X No 5 Pending Jul 5 2012 0127 hrs 2 Accident Investigation 28f Location (Street and Number or Rural Route Number, City 28e, Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be 3 Suicide or Town, State) Baltimore, MD 21217 determined (Specify) Multi-Family Apt. 2343 North Eutaw Place 1st Floor 4 X Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗶 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of O.C.M.E. July 5, 2012 completed cause of death (Item 23a) dress of person wh 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, 1 32 Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/  $\overset{ ext{Month}}{ ext{July}}$ 2012 5:00 Dean William Kenney Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1730 Freeland Road Baltimore Freeland Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 218-40-2201 71 Director 1 🖾 1 2 🗆 F 1941 Pennsylvania Usual Residence of Decedent or 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2X No MD **Baltimore** Freeland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21053 USA 1730 Freeland Rd. 12. Was Decedent Ever in U.S. Armed Force ↑ 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes Yes, Give hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: white 3 🗆 Widowed 4 🗆 Divorced Specify: Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "i Elementary/Secondary (0-12) College (1-4 or 5+) janitorial custodial Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ပ Essie Warner George Kenney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1730 Freeland Rd; Freeland, MD 21053 19a. Informant's Name/Relationship (Type, Print) Ellen Kenney - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) ignal F. eral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ idne disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical The law requires that the death certificate be Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Lyes 2 L 9 Unknown Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a Was an has page 2 performed?

1 Yes 2 No death? certificate 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending M 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 6

DHMH 17 Rev 06-201

State Registrar 30. Name and address of

rson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Chung Kih Kim Month Jul 27, 2012 11:30 A Physician/ Medical 4c. County of Death **Howard** 4a. Facility Name (if not institution, give street and number)
10211 Sunway Terr. 4b. City, Town, or Location of Death Ellicott City Examiner If Under 24 Hrs. Birthplace (State or Foreign Country)
 Korea If Under 1 Year . Age (In yrs. last birthday) **95 Funeral** 113-56-6804 Davs Hours Morally 978, 49917 Director 1 M 2 A F Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director **Ellicott City** MD Howard 1 Yes 2 No Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 10211 Sunway Terr. 21042 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Completed by Korean 1 Yes 2 No Specify: Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) A+ Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname, Myo Joo Kim 17. Father's Name (First, Middle, Last) **Pyung Hoon Min** မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 87 Stonehurse Dr. Tenafly, NJ 07670 19a. Informant's Name/Relationship *(Type, Print)* **Kwang Hae Chun Daughter** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 30 July 12 WESTPIELD, NJ Donation 5 - Other (Specify) FAIRVIEW CEMETORY of Funeral Service 22. Nar Stack Purieraf Höme, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nediate Cause (Final disease or condition resulting in death) Sequentially list conditions Physician/Medical Examiner ending physician and use as the burial-tran rate has been signed by the attending physician are page 2 should be detached for use as the burial Completed by

Physician/ Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

director, within 24 hours after death.

To the Funeral Director. After this completely filled in by the funeral dir

Certificate: To Be

Medical

Date filed (Month, Day, Year)

JUL 3 0 2012

Division of Vital Records, P.O. Box 68760

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to /r s a consequence of):					
resulting in death) Last	Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions or	ontributing to death but not resulting in the un	derlying cause given in Part I.		co use contribute to the cause of death?		
			24a. Was an autopsy performed 1  Yes 2			
25. Was case referred to medical		26. Place of Death (Chec	ck only one)			
examiner? 1  Yes 2 No	Hospital: 1  Inpatient 2  ER/Outpatient	3 DOA Other: 4 Nursing H	ome 5 Residence	6 Other (Specify)		
27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident □ Investigation		28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	v injury occurred		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)		
(Check 2 Medical Exami	sician: To the best of my knowledge, death or ner. On the basis of examination and/or investig se Practitioner: To the best of my knowledge, or	ation, in my opinion, death occurred	at the time, date and pla	ace, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier		29c, License number	29d.	Date signed (Month, Day, Year)		

Registrar DHMH 17 Rev 06-2011

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylan	-	rtment of H tificate of D		nd Mental Hy		0.0	10	01000
			Registrar  1. Decedent's Name (First, Midd	le, Last)		Cer	uncate of L	reauri	2. Date of De		). <u> </u>		3. Time of Death
	Physicia Medic		Lysle	Geraldine		Krout			July 23	3, 20	312 Yea	ar	4:30 a M
partie.	Examin		4a. Facility Name (if not institution Glichrist				4b. City, Town, or Columbia		Death		. County of D	eath	
30	Funeral		5. Social Security Number		e (In yrs. la	st birthday)	If Under 1 Year	If Under 2		th	g.	Birthpla	ace (State or Foreign
	Director		218-28-4166	1 □ M 2 🔏 F	78	Yrs.	Months Days	Hours	Min. (Month, Da			Country ary]	// Land
	and show lat	or	Usual Residence of Decedent  10a. State  10b. Count	,		, Town or Loc	ation	<u> </u>				10	d. Inside City Limits
	Maryla 28a-f	Director	MD Balti	more	Ha1	ethorp							1 Yes 2 X No
	ith the 3a or it be n		10e. Street and Number	Aamara			10f. Zip Code 21227			10g. Ci	tizen of What	Countr	y?
	eath w	Funeral	603 Washingto	12. Was Decedent B	Ever in U.S	13. V	Vas Decedent of Hi	spanic Origin	n? (Specify Yes or No-		14. Race - A		
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by I	1 ☐ Never Married 2 🛣 Ma 3 ☐ Widowed 4 ☐ Divorce	If Von Civo	No		Yes, specify Cuba		Puerto nicari, etc.)		Black, W		
2-00	hours "natur dical B	plete		ent's Education nest grade completed)			ent's Usual Occupa aind of work done d		of working	16b. K	(ind of Busine	ess/Indu	ustry
21215-0036	ithin 72 ene. r than '	Com	Elementary/Secondary (0-12)		i+)	Ìife. DO	NOT use retired)	g			Factor	v	
nd 2	filed wal Hygi	Be	17. Father's Name (First, Middle	Last)		- Ocame			's Name (First, Middle,		Surname)		
Maryland	uld be I Ment narked natic e	2	Lyle	Chand1	er	115			garet		Gove	-	
Ma	12 shoulth and 27 is r		Walter A. Krou		and)				or Rural Route Numbe , Halethor				ode)
Baltimore,	of Head of Head If Item		20a. Method of Disposition	n 3 🗆 Removal from State	20b. P	lace of Dispo	sition (Name of	- :	Date		ocation - City		n, State
tim	permit. Page 'Department o Important: If any injury or once.		4 Donation 5 Other	(Specify)	1		Park						aryland
Ba	permil Depar Impor any in		21. Signature of Funeral Service	Licensee		22			Loudon Pa Ave., Balti				
			23a. Part 1. Enter the disease, shock, or heart failure. List	or complications that caused only one cause on each line	9.			g, such as ca	ardiac or respiratory ar	rest,			Approximate Interval Between
	Pnynician/ Medical	0.7	Immediate Cause (Final disease or condition resulting in death)	a LUNE		ANCE	R					-	Onset and Death
۲	Examiner			Due to (or as	a consequ	erice oi).							
	d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):							
	xecute n and al-tran	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):						+	
09	ate be executed physician and the burial-transit	edical		d								$\bot$	
3876	ertificat ding ph		IF FEMALE:	23c. If yes, outcome	of pregna	ncv							
Box 687	eath certifica attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No	1 Live Birth 4 Pregnant a	2 Feta	I death 3	Ectopic pregnanc Other (specify)	У			23d. Date of Month		y Day Year
P.O. B	es that the dea signed by the a be detached t	Phys	g 🗌 Unknown	g L Unknown		ulaine in the u	ndarking cours giv	on in Port I	20. Pida				and a decided
s, P.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by	Part II. Other significant condi	nons contributing to death L	out not resi	unting in the u	inderlying cause giv	ell li l'ait i.					cause of death?  ably 4 Unknown
cord	law requires has been sig ge 2 should b	plete							24a. Was	psy	prior	to com	sy findings available pletion of cause of
Re	: The la								1 🗆 Yes	ormed? 2 N	deatl	h? Yes 2	2 🗆 No
/ital	ysician: The is certificate director, paç	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ent 2	ER/Outpatier	Othe	257	(Check only one) sing Home 5  Resi	dence f	6 M Other /S	necify)	HOSFICE
of	ding Phys h. After this funeral d		27. Manner of Death  1 Natural 5 Pend	28a. Date of inju	iry	28b. Time of injury	28c. Injury work	/ at	28d. Describe			podity	
sion	I or Attendii after death. Director: A in by the fu	Certificate:	2 Accident Invest 3 Suicide 6 Coul	tigation d not be	ury - At ho	me farm stre	M 1 🗆	Yes 2 🗆 N	No 28f. Location 6	Street an	nd Number or	· Rural F	Route Number
Division of Vital Records,	ial or A s after al Direction be		4 Homicide dete	mined building, et			,,,		City or To				
	To the Hospital or Attendir within 24 hours after death.  To the Funeral Director: Af completely filled in by the fu	Medical	(Check 2 Medica	ng Physician: To the best of Examiner: On the basis of a ng Nurse Practitioner: To the	xamination	and/or invest	igation, in my opinio	on, death occ	curred at the time, date	and place	e, and due to t	the caus	se(s) and manner stated
	To the vithin To the comp	2	29b. Signature and title of contri	<del> </del>		,, <u>-</u>	29c. License	number			ate signed (Mo		
	•		1 lyes	ances	landi: #:	22=) /T:	D72	134		Jul	423	2	-012
			30. Name and address of person SYED © ABIS A	/ /22		FRAG	1 ANE	. C	DLUMBIA	MI	210	04	4.
	Sta Registr		31. Date filed (Month, Day, Year,	012 S2. Registr	ar's Signat	ture	ميا						
	ogioti			- Mariet	7-1	17							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ EROY 4:59 P M 2012 Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** KRADFORD CD DAKS KEHAB FACILIT LINTON PR GEORGE If Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In\_yrs. **Funeral** (Month, Day, 1 № M 2 🗆 F 3 Months Hours Min Director Usual Residence of Decedent 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director notified MI 28a-f PRINCE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r 20744 SA items permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian ed other than "natural", or iter event, the Medical Examiner Armed Forces?

1 X Yes 2 \( \subseteq \text{No} \)
If Yes, Give \( \frac{9+2}{9+6} \) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 X Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) id Mental Hygiene. marked other tha OLOYEE GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LINDSAY other traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) <u>.e</u> Health tem 27 JANGHTER TA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1X Burial 2 Cremation 3 Removal from State BRENTWOOD 07.27.2012 4 ☐ Donation 5 ☐ Other (Specify) ORT 21. Signature of Funeral Service Licensee Upshur De 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and that initiated events Due to (or as a consequence of): resulting in death) Last burial ed by the attending physician detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner:—In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier an the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Gertifying Nurse Practioner: To the best of my knowledge, death occurs id at the time, date and place, and due to the cause(4) and manner as state only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D35206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Wingsh Rond Fort Whethered 1 Duna un

/ DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ DISON 11.30 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TIMORE MITIMORE (OUN) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) unk **Funeral** Min 230-38-5157 **Director** 1 🕅 M 2 🗆 F 27, or items 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Examiner must be notified at Director 1 🗆 Yes 🚈 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 Funeral USA 543 Tunbridge Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?unk
1 Yes 2 No 11. Marital Status unk 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatin events. College (1-4 or 5+) Elementary/Secondary (0-12) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N. Calvert St; Baltimore, MD 21202 19a. Informant's Name/Relationship (Type, Print) Frieda Jones - guardian 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from Stat 4  $\square$  Donation 5  $\stackrel{\bullet}{N}$  Other (Specify)  $\stackrel{\bullet}{\text{in}}$  State 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** 101 Esquentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No Yes eral Director. After this certific filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manne Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certified

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day,

EV7HW

5716

ame and address of person who completed cause of death (Item 23a) (Type, Print) MITSAN

3 0 2012

2. Registrar's Signature

29d. Date signed (Month, Day, Year)

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Julu 26 (AKA Irving Maggin) 11:24 ам Irv Maggin 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 369-20-4826 Director 1 🗙 M 2 🗆 F 86 09/28/1925 Michigan ifiled within 72 hours when that Hygiene.
Ital Hygiene.
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Italied italied italied italied italied. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Lake Leesburg Florida 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25434 Crestwater Drive 34748 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 V Yes 2 No 1944—
If Yes, Give
Year or Dates. 1946 Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Commercial Construction Engineer Manager Be permit, Pege 1 and 2 should be filed.
Depertment of Health end Mental Hy Importent: If item 27 is marked oth eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Morris Maggin Becky Maller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25434 Crestwater Drive, Leesburg, Florida 34748 Lue Maggin - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Judean Mem. Gardens 07/29/2012 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart thilure. List only one \_\_\_\_ se on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consiquence of ettending physicien end for use as the burlei-trensit To the Hoepital or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burlei-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check natu and title of 2041 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	e of Maryland / De			Mental Hy	giene		
			State Registrar		Certificate of L	Death		Reg. No. 2	112	26070
PI	hysicia	n/	1. Decedent's Name (First, Middle, Last)  David C Millberry				Date of Dea     Month		Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give street and		Als City Town or	r Location of Deatl	1		2012	9:27 PM
) '	Examin	er	University of Maryland M			timore	II.	4c. County	of Death	
Fı	uneral		Social Security Number 6. Sex	7. Age (In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	O. Date of Dire			place (State or Foreign
Di	rector		220-42-9653 1X м 2 □	F 65 Yrs	Months Days	Hours Min.	Jan. 5,		Count	yland
pu	how	٦c	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	r Location		Joans J	1347		0d. Inside City Limits
faryla	3a-f s iffied	Director	Maryland Carroll		Taneyt	own.			[	1 X Yes 2 □ No
the N	or 2		10e. Street and Number		10f. Zip Code			10g. Citizen of	What Coun	itry?
with	ıs 23a nust b	Funeral	202 Morning Frost St.		2	1787		U.S	.A.	
<b>21215-0036</b> within 72 hours after death with the Maryland giene.	r item ner n		Armed	Forces?	<ol> <li>Was Decedent of Hi If Yes, specify Cuba</li> </ol>	ispanic Origin? (Sp in, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - America	
)36 after	al", o	d by	3 Widowed 4 Thisased If Yes,	es 2 <b>X</b> No Give r Dates.	1 🗌 Yes 2 🕱 No	Specify:		Specify		Lack
<b>21215-0036</b> within 72 hours after giene.	natur lical E	Completed	15. Decedent's Education	16a. De	ecedent's Usual Occup			16b. Kind of B		
215 E 72	nan " Med	duic	(Specify only highest grade comple  Elementary/Secondary (0-12)  College		ive kind of work done c e. DO NOT use retired)	during most of wor	rking	700771110010	0011100071110	
d with lygien	her tl	Be C	10		labore					coducts
land be filed ental Hy	ed of	To B	17. Father's Name (First, Middle, Last)  Charles O. Millberr				ne (First, Middle, I .a Irene			
Maryland 2 should be filed th and Mental Hy	is marked or aumatic eve		19a. Informant's Name/Relationship (Type, Print)	-	ailing Address (Street a					20 da)
Me d 2 sh aith ar	P 5		Ruth M. Smith/ sister	I .	) Westcliff			ster, M		
of Heal	f item r othe		20a. Method of Disposition	20b. Place of Di	sposition (Name of crematory or other place		Date	20c. Location		
Page ment o	ant: I		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	on oute	Joy Cemeter		3/2012	Uniont	own,	MD
Baltimore, permit. Page 1 and Department of Hea	Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	ther	22. Name and Addres	ss of Facility Ha	rtzler F	uneral	Home,	P.A.
		H	23a. Part 1. Enter the disease, or complications th	at caused the death. Do not			lew Winds or respiratory arm		21//6	Approximate
- Pnys	ician/	gi y	shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition	Loaqulopath	,					Interval Between Onset and Death
1	edical miner		resulting in death)	to (or 🐲 a consequence of):		The second			$\neg$	
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p	ısit	Examiner	course Enter I Indextuing	to (or as a Insequence of): Left atrial	mass	31. 32.				
executed	າ and al-trar	Exa	triat irritated events	to (or as a consequence of):	(4 1003 )				-	
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certificate be	ng ph as th	W 1	IF FEMALE:							
th cer	been signed by the attending p should be detached for use as	Physician/M	23b. Was decedent pregnant 23c. If yes, in the past 12 months?	outcome of pregnancy ve Birth 2  Fetal death	3 🔲 Ectopic pregnanc	у			te of delive	·
BOX e death c	the at	ysic	1 Ves 2 No 4 P	regnant at time of death nknown	5 Other (specify)			Mo	nth	Day Year
cords, P.O.	ed by detac		Part II. Other significant conditions contributing t	o death but not resulting in th	ne underlying cause giv	ren in Part I.	23e. Did to	bacco use contr	ibute to the	e cause of death?
S,	n sign	ed by	Right ventricular.	failure			1 🗆 Y	′es 2 □ No	3 🗌 Prob	pably 4 Nunknown
Oro	s beer	plete	3				24a. Was a			sy findings available
He la	ite ha: page 2	Completed					autop perfor 1  Yes	med?	orior to con death?	npletion of cause of
ian:	ctor, p	BeC	25. Was case referred to medical examiner?		26. Pla	ace of Death (Chec		ZZZNO	i Li ies ,	2 🗀 140
hysic	al dire	욘,	1 X Yes 2 □ No	X Inpatient 2 ☐ ER/Outpa		er: 4 🗌 Nursing H	ome 5 🗌 Resid	ence 6 🗆 Othe	er (Specify)	
n ol	funer	ate:	1 Natural 5 Pending	ate of injury Ionth, Day, Year) 28b. Time Injur	y work	?	28d. Describe ho	ow injury occurre	ed	
SIOI Attend	ctor:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ace of Injury - At home, farm,	4 1 2 2 2 2	Yes 2 No	28f. Location (Si	treet and Number	r or Rumi I	Pouto Number
DIVISION OF VITAL RECORDS, tal or Attending Physician: The law requires after death.	d in b			ilding, etc. (Specify)	street, factory, office		City or Town		n Or Hurair	noate rvarriber,
DIVISION OF VITAI RECC To the Hospital or Attending Physician: The law within 24 hours after death.	Funera stely filk	Medical	29a. Certifier 1 Certifying Physician: To th	basis of examination and/or in	vestigation, in my opinio	n, death occurred a	at the time, date ar	nd place, and due	to the caus	se(s) and manner stated.
o the	o the	ž	only one) 3 Certifying Nurse Practition 29b. Signature/and title of certifier	ner: To the best of my knowled	lge, death occurred at the 29c. License	ne time, date and p	lace, and due to th	ie cause(s) and m 29d. Date signed	nanner as st	tated.
H 8 F	- 0		. // , , , ,	ent physician		6435E10			201	
		ļ	30. Name and address of person who completed o	ause of death (Item 23a) (Tun	a Drint\					
			Charlie Evans De	pt et Sugery, D	Wishim of Card	iac Susquery	1. UMMC	22 5, 61	cane St.	isaltinuz no
<b>∦ р</b> .	Stat egistra	_		. Registrar's Signature						
	egistie		JUL O O COIL CHANN	7/4. 19 W						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	101	partment of Health and Nertificate of Death		ene 3. No. 2012	24071			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death			
~	Medic	al	Eleanor Ruth Mortimer  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July 25	, 2012	1:30 AM M			
	Examin	er	Potomac Valley Nursing Home	4c. County of Death  Montgom						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Rockville  // If Under 1 Year   If Under 24 Hrs. Months   Days   Hours   Min.	8. Date of Birth	9. Birth	place (State or Foreign			
	Director		293-20-2725 1 □ M 2 <b>X</b> F 92 Yrs	Months Days Hours Will.	(Month, Day, Ye		nessee			
	and show at	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits			
	Maryla 28a-f	Director	Maryland Montgomery Silver	Spring			1 ☐ Yes 2X No			
	th the		10e. Street and Number	10f. Zip Code		g. Citizen of What Cou	*			
	ath wil	Funeral	11703 Hatcher Place  11. Marital Status   12. Was Decedent Ever in U.S.   13.	20902  3. Was Decedent of Hispanic Origin? (Spe		United States  14. Race - American Indian.				
ထွ	ter de	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No	<ol> <li>Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 No Specify:</li> </ol>	Rican, etc.)	Black, White,	etc.			
93	ours af tural" al Exa	ted	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.				hite			
7	an "na Medic	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/II	iness/Industry			
2	withir giene rer tha t, the		Elementary/Secondary (0-12) College (1-4 or 5+) His	tology Technician		Hospital				
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland is and Mental Hygiene.  F is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)  James Bernard Nanney	18. Mother's Nam	e (First, Middle, Mai	iden Surname)				
ary E	of and 2 should be of Health and Ment fitem 27 is marked rother traumatic errother traumatic			ailing Address (Street and Number or Rura		itv or Town. State. Zip	Code)			
	nd 2 st salth a n 27 is er trai			703 Hatcher Place,			20902			
ore	je 1 ar t of He If iten or oth		1 Burial 2 X Cremation 3 Removal from State cemetery, c	position (Name of rematory or other place) July	7 29 <b>.</b>	0c. Location - City or 7				
Baltimore,	permit. Page 1 a Department of I Important; If its any injury or ot		4 Donation 5 Other (Specify) Montgomer	y Crematorium 20	$12 \mid 1$	Bethesda,				
Ва	permi Depar Impol any ir	9		22 Name and Address of Facility Robert A. Pumphrey Fund 7557 Wisconsin Avenue,			vy Chase, Inc 14			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		or respiratory arrest.	,	Approximate Interval Between Onset and Death			
~~ ) }	Medical		Immediate Cause (Final disease or condition resulting in death)  Cardiopulmonary  Due to (or as a consequence of):	y Arrest			Oliosi dila Bodali			
	Examiner		End Stage Deme	ntia						
	p ti	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):							
	ecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last   C							
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876	tificat ing ph e as th	Med	IF FEMALE:							
Box 687	ath cer attendi for use	Physician/Medical	23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1 \in \text{Live Birth} 2 \in \text{Fetal death} 3	B		23d. Date of deliver Month	very Day Year			
	the de	hysi	1   Yes 2 1 No 9   Unknown	o E o thor (oposiny)						
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 2 🗓 No			
ta	sician: certific irector,	Be	25. Was case referred to medical examiner?  1   Yes 2   No   Hospital:   Input least 2   EP/Output	26. Place of Death (Check						
of V	g Physer this	e: To	27. Manner of Death 28a, Date of injury 28b, Time	of 28c. Injury at	ome 5 U Residence 28d. Describe how	ce 6 Other (Specifing Injury occurred	ý)			
on	endin eath. or: Aft	ficat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	/ work?  M 1 □ Yes 2 □ No						
ivis	l or Att after d Direct d in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	il Route Number,			
Ц	Hospita 24 hours Funeral tely fille	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, dea (Check 2 Medical Examiner: On the basis of examination and/or inv	th occurred at the time, date and place, a restigation, in my opinion, death occurred a	nd due to the cause t the time, date and p	e(s) and manner as sta place, and due to the ca	ted. ause(s) and manner stated.			
	o the	M	only one) Certifying Nurse Practitioner: To the best of my knowled 29b. Signature and title Certifier	ge, death occurred at the time, date and pla 29c. License number		cause(s) and manner as d. Date signed (Month,				
	F > F 0		· / n.	69188		7/25/1	2			
			30. Name and address of person who completed cause of death (Item 23a) (Typi		)6 D 1	11. 1	1 1 20050			
	Stat	te		lar Drive, Suite 20	o, Kockv	ille, Mary	land 20850			
	Registra		31. Date filed (Month, Day, Year)  22. Registrar's Signature	West -						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ July 26, Carl Robert Mahder 5:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Wilson Health Care Center Gaithersburg If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 6. Sex 1 **X** M 2 □ F 8. Date of Birth . Age (In yrs. last birthday) **Funeral** Days 100 Ohio 284-40-6162 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10c. City, Town or Location event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Maryland Gaithersburg Montgomery 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 20877 United States 211 Russell Avenue #64 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced WWII Completed Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. 27 is marked other than " College (1-4 or 5+) 5+ Elementary/Seconday (0-12) U.S. Government Economic Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည Elizabeth Lachner Samuel Mahder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Russell Avenue #64, Gaithersburg, MD 20877 Audrey L. Mahder/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 29, cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium Bethesda, Maryland 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen RODERT A. Fumphrey Funeral Home, Bethesda—Chevy Chase, Inc. Mullia M01173 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ptwaician/ disease or condition Medical resulting in death) **Examiner** Esquer tially liet so ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine requires that the death certificate be executed and -tran: resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 1 Yes 2 9 Unknown n signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of 24 hours after death.

Funeral Director: After this certificate has performed? dicele calities, Prostatie careinon 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deat (Check only one) Be Hospital 1 ☐ Yes 2 ☐ No Other 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred **Hospital or Attending** work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🚅 🗲 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) July 26, 2012 NAshert Duselbar 04-165 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) 201 Russell 4 ML 200 Carthersony ML 200 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Melvin Moore Jr. 3:06 Loil Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death MN Baltimor N/A ne If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) 428-32-4949 **Director** 1 ★ M 2 🗆 F 85 09/04/1926 Missippi or 28a-f show 10b Counts 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits by Funeral Director MD N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3730 Winterbourne Rd. 21216 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other the state of the stat 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation B&Tuckey of the state of the st (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) School System Social Worker Super years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin Moore Fannie Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Moore(son) 2415 Madison Ave., Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State on-site Crematory -/2/Baltimore, MD Denation 5 Other (Specify) uneral Service Licensee ignature of 30sepHddFsBrown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Sepsi5 disease or condition 24 HOURS Medical resulting in death) s a consequence of): **Examiner** 24 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury o (or as a consequence of) the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ျင MOORE 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending work 24 hours after death. Funeral Director: A 1 🗌 Yes 2 🔲 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completely f (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) the cause(s) and manner as stated 29b. Signature D63305 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 0 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Mark 200 7018 AM Ja h 36 Obek /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 216-76-8252 1 MM 2 □ F 4-24-197 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 3a or 28a-f show be notified at 10a. State 10h County 1 ☐ Yes 2 No Director DUNDALK MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 806 ms 23a must be 11. OALAN 21222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 Yes 2 No Specify White If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) GOLDS GYM CUSTODIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SusAN WASHINGTON OBER RICHARAS George JR ဂ္ J. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Street MD 21154 4356 St Clair Bridge RR George W. OBER-FATE 20b. Place of Disposition (Name of cemetery, crematory or other pl 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Odenton. 30 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Füheral Service Licensee 22. Name and Address of Facility TOSPLNZANNINO 2635-CONKINS Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failu only one cause on each line Immediate Cause (Fin-My exalenic Crisis Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner CENTRACTION APPROVED BY MEDICAL EXAMINES Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Day Month Vear in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Imoney discase. disease Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an leia wy dog de fect 2 🗌 No 1 🗌 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Dog bite 1 
Natural 0 500 PM 06/22/2012 2 Accident 28f. Cation (Street and Number or Rural Route Number, City or Town, State) SI JEAN EHE AVE. DUNDAUK, MD ZIZZZ 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NP1/45 7672701 Joshua Grimm MD 28 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSHVA Orinn 4940 Eastern Avenue, Baltimore, MD, 21224 MO 32. Registrar's Signatur 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 11595

State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27<sup>Pay</sup> 2012<sup>ear</sup> 4:00 A M JMT₩ Abraham Lincoln Preece Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sykesville Carroll Sun Valley . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) 292-16-3001 Director 1 ☑ M 2 ☐ F 94 10/3/1917 KY Usual Residence of Deceder an "natural", or items 23a or 28a-f show Wedgel Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Sykesville Carroll 1 Yes 2 No 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States 21784 110 Terrapin Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? 1945 Black, White, etc. ۵ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify 1946 3 √ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 tal Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) ž US Steel Iron Worker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Importent: If item 27 is marked oth eny lining or other traumatic event once, is 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Corneilius Preece Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Danmarth Rd., Sykesville, MD 21784 Larry Preece/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/2012 Hamden, OH Hamden Cemetery Signature of Euro 2Burrier Gue Enlivruneral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Onset and Death Immediate Cause (Final ementis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician abe detached for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2-X No 3 Probably 4 Unknown 1 🗌 Yes After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗌 No 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 ☐ Yes 2 🗗 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) AJI မြ 1 Inpatient 2 ER/Outpatient 3 DOA 124 hours after death.

• Funeral Director: After thi letely filled in by the funeral. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hound to the funer completely file 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Westminst 1A (Amou) 31. Date filed (Month, Day, Year) State 2012 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ John Edward Pekala, Jr. Jul 24. 2012 8:00 A M Medical 4c. County of Death **Howard** 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 8700 Ridge Rd. #414 **Ellicott City** Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 190-26-0282 1 🔀 M 2 🗆 F Months Davs <sup>(Month Day</sup>, 1935 Country) PA **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director MD Howard **Ellicott City** 28a-f 1 🗌 Yes 2 📉 No 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? be Funeral 23a 8700 Ridge Rd. #414 21043 U.S.A. must permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: amy injury or other traumatic event, the Medical Examiner musonce. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired)

Management (Specify only highest grade completed) Elementary/Seconday (0-12) Gollege (1-4 or 5+) Marketing Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) John Edward Pekala Sr. ၉ a. Informant's Name/Relationship (Type, Print) **Gregory Pekala Son** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10040 Culverine Rd. Eflicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Temation 3 Removal from State Atlantic Crematory or other placel Glen Burnie, MD 7.1 4 Donation 5 Other (Specify) <sup>22. Nam</sup>Sারেটে শিলারেরিশিটিme, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ature of Funeral Se Part 1. Exter the disease, or complications that caused shock, or heart failure List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Preysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Cause (Disease or iinjury that initiated events and -trar Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Year page 2 should te detached 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. signed b 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 24 hours after death. 1 Yes 2 🗌 No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and the of certifier

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Olumbic Maylan

ss of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore, Maryland 21215-0036 RECSON, Barbara

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deat -Month Physician/ 35.0 Medical 4c. County of Death
Carroll institution, give street and number)
906 Roller Coaster Ct. 4b. City, Town, or Location of Death

Mount Airy **Examiner** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 216-30-5022 **Funeral** 1 M 2 F Months Monthu Raz, 1935 Country) MD Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location ermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Carroll **Mount Airy** ms 23a or 28a-f s must be notified 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 906 Roller Coaster Ct. 21771 Funeral U.S.A. iral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status 1 Never Married 2 Married Yes 2 No epartment of Health and Mental Hygiene. Import: Int if item 27 is marked other than "natural", or iny injury or other traumatic event, the Medical Examin noe. by White 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates Specify. Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Wianagement 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business 17. Father's Name (First, Middle, Last)
Charles Edgar Maddox Be . Maiden Surname, 18. Mother's Name (First, Middle) Lillian Brookman မ 19h Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9048 Albaugh Rd. New Windsor, MD 21776 19a Informant's Name/Relationship (Type, Print)

James Bonneville Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burai 2 Cremation 3 Regioval from State Jul 31, 2012 cemetery crematory or other place) Union Bridge, MD Other (Specify 22. Nam Stack Purrer all Prome, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ignatu Approximate Interval Between Onset and Death Part 1. Enter the desease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final METHSTATIC Physician/ OVANIAN lisease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death the 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2. No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2. No s after death.

Director: After this ore in by the funeral dire 1 Inpatient 2 ER/Outpatient 3 IDOA မှ 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5  $\square$  Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signaturé and title of dertifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar DHMH 17 Rev 7/2009

State

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

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iled (Month, Day, Year,

2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death S:04 P M 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 Day Year Physician/ Ward M. Peterson 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital N/A Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) Months **Director** 1 🔀 M 2 🗆 F 11/11/1926 85 Alabama 28a-f shov 10d. Inside City Limits 10b. County 10a. State 10c, City, Town or Location notified at Director Yes 2 No MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō event, the Medical Examiner must be Funeral 4169 Crest Heights Rd. items 23a 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces Black White etc. ö þ 1 Never Married 2 Married Yes 2X No Maryland 21215-0036 hours after 1 Yes 2 X No Specify Specify: Black If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Flementary/Secondary (0-12) 3rd Grade College (1-4 or 5+) Truck Driver C&S Faulkner 1 and 2 should be filed with of Health and Mental Hygien item 27 is marked other the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Jessie Peterson Lassie Eddins injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sara Brown(daughter) Baltimore, MD 21215 4169 Crest Heights Rd., Baltimore, tem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cem. 08/03/12 Baltimore, MD 21. Sig / ture o / Funeral Service Licensee Joseph Adres Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final ENCEPHALOPATHY Physician/ ATIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** DISEASE 4 MXMOUD N TASTA-II Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir YEGRS CANCER attending physician and I for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last OSTATE Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death signed by the at Id be detached fi Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 2 No ER/Outpatient 3 DOA 1 🗌 Yes Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Manner of Death 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital
within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.D 07-25-2012 D0065440 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE

State Registrar

DHMH 17 Rev 06-2011

SHAHZAD

31. Date filed (Month, Day, Year)

3 0 2012

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32. Registrar's Signature

312 N. MLK JR. BLUD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July Lillian Anna Russo Ам 28 2012 7:19 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center For Hospice Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 212 28 2713 98 Director 1 □ M 2 🗗 F Feb.28,1914 Maryland Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location within 72 hours efter death with the Maryland 10d. Inside City Limits Director Maryland Baltimore Rosedale 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1606 Chesaco Avenue 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married ≥ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home it. Page 1 and 2 should be filed with thrent of Health end Mental Hygien rtent: If item 27 is marked other i jury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First\_Middle\_Maiden Surname) Frank Plumhoff Unk. Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Carrow (Niece) 1606 Chesaco Avenue Baltimore, Maryland 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 s
Department of H
Importent: If ite
eny Injury or ot 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 7/31/2012 Baltimore, Maryland Signature of Funeral Service Licensee <sup>22, Name and Address of Facility</sup>
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex an Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition P.W Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospitel or Attending Physician: The law requires that the death certificate be executed 24 hours after death. signed by the attending physicien and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 5 Other (specify) Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been significate has been significated and funeral director, page 2 should it 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 No Yes 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 2 No မှု 1 🗌 Yes To the Hospitel or Attending Physis within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Manner of Death Certificate: 28b. Time of 1 Natural 28d. Describe how injury occurred 28c. Injury at 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 Certifying Norse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and e of certifier 29d. Date signed (Month, Day, Year 8215000 who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (I onth, Day, Year State 30 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard James Robbins, Jr. 49 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** 8. Date of Birth (Month, Day, Year) Feb. 2,1960 Birthplace (State or Foreign Country) **Funeral** Hours Min. 220-64-3012 Director 1 🔀 M 2 🗆 F Maryland 52 28a-f show 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore 1 Yes 2 X No Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 7605 Fitch Lane 21236 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 X Never Married 2 Married Completed by ö 1 ☐ Yes 2 X No Specify. Specify: White should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Landscaper Landscaping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard James Robbins, Sr. Cecelia Ann Gersey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 1100 Gebhart Road, Windsor, Pennsylvania 17366 Michael Robbins: Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-26-12 Hanover, Maryland CremationCenterof Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events -transit hasis and Due to (or as a consequence of) resulting in death) Last signed by the attending physician a d be detached for use as the burial-Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Year Month Day Pregnant at time of death 2 No filled in by the funeral director, page 2 should be detached g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No ျ 1 🗌 Yes 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No injury **▼** Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive Baltimore MD 2123 State Registrar

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	Divisionis		Decedent's Name (First, Middle, La	-			2. Date of Dea	ith	3. Time of Death					
	Physicia Medic	al .	Harriet P. Reni			ii (Baaila	$J_{\mathbf{u}}^{Month}$ 2		8:30 P M					
)	Examin	er	4a. Facility Name (if not institution, giv Medstar Montgomery		r		fown, or Loca . <b>nev</b>	tion of Death	4c. County of De Montgom					
	Funeral		5. Social Security Number 6. 5	day) If Under		nder 24 Hrs. urs Min.	8. Date of Birti	h	9. Birth	rthplace (State or Foreign				
	Director		108-12-5067 Usual Residence of Decedent	□ M 2 <b>X</b> ) F	94 Y	rs.			July 3,			w York		
	land show dat	to	10a. State 10b. County		10c. City, Town or Location					1	10d. Inside City Limits			
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036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates.	Ever in U.S.  13. Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican,  1  Yes 2 No Specify:			xican, Puerto F	oify Yes or No- lican, etc.)	ack, White,	- American Indian, s, White, etc. White			
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, Mary	nd 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (		Mailing Address DBox 25				; City or Town	Code)				
Baltimore, Maryland	. Page 1 ar ment of He tant: If iter jury or oth		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State   cemetery, crematory or other place)   J <sub>11</sub> 1 v 27								c. Location - City or Town, State ethesda, Maryland			
Bai	permit Depart Impor any in		21. Signature of Funeral Service Licer	/) /	01173	Robert A 17557 Wis	Address of F Pumphi Consin	rey Funer Avenue, I	al Home, Bethesda	Bethes Marvla	da-Chev	y Chase, Inc.		
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00	icate be executed physician and is the burial-transit	edical		∎ <sub>d.</sub> <u>Diarrh</u>	·a							Days		
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Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	al Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	y - At home, fan (Specify)	m, street, factory	, office			. Location (Street and Number or Rural Route Number, City or Town, State)					
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	<b>6</b> ≥ 6 0	29b. Signature and title of certifier  29c. License number  D0073699  29d. Date signed  D1 2  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									26/	10 (2 )		
)			18101 PRIN			RIVE		LNEY		10	208	332		
	Sta Registr		18101 PRINCE PHILIP PRIVE OLNEY MD 20832  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature  34. Aparle											

Please Type or Print in Black Indelible Jak. Fraure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7.01AM -Medical Facility Name (If not institution, give street and number) 35 1.2 Refisterstown Road Examiner 4c. County of Death 8. Date of Birth (Month, Day, 09 26 if Under 1 Year I if Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Min Director Yrs. 214-33-4867 Trinadad Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No MD NA Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3512 Reisterstown Road 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black "natural", Specify 3X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled 12th grade 2yrs Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ည Sylvester Henry Clair Henry traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important: If item 27 is any injury or other transons. 3512 Reisterstown Road Jamela Wilson-Daughter Baltimore, Md 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date emetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 7/27/2012 Baltimore, Md On-Site 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Livers March For H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last the burial-transit and attending physician Physician/Medical Records, P.O. Box 687 as IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy Hospital or Attending Physician: The performed 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29c. License number 025438 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7-20-2014. anelles 30. Name and address of person who completed cause of death (Item 23a) (Type Print)/Th Center - 3:5 N. CAlvert Utt. 41th Floor 1 C 01/202 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4-24 M IWOWI OT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 088 3 m HOSPITA SILVER MONTGOMER 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 016-35-4495 Director 1 ☑ M 2 ☐ F 101 New York Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Funeral Director 1 Yes 2 No DC NGTON 10e. Street and Numbe 10f. Zip Code 5 10g Citizen of What Country? 23a MASSACHUSETT AVE 0008 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify "natural", 3 Widowed 4 Divorced STIHW Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) the Smithsonian Institute 8 historian/museum curator 12 of Health and Mental Hyginitem 27 is marked other other traumatic event, t Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 HOL FOREST CROSS HOSPITA GLEN RD MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place o <u>=</u> 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother Specify in State ò Department of Important: If any injury or once. 22. Name and Address of Facility State Anatomy Foard 21. Sign of re of superal Supe 655 W. Baltimore St; Baltimore, MD 21201 22 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ MYOCARDI NFAR Medical Due to (or as a consequence of): Examiner FASDIOMYAPAT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). FIBRILL HTRUPE and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the at d be detached fo Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed? death? 24 hours after death.
Funeral Director: After this certificate | 2 🗌 No 1 Yes Yes or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner's 1 Yes 2 No Other: ျှ 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident 2 Accident
3 Suicide
4 Homicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifie

31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

82. Registrar's Sign

SHERK

1500 FOREST

CLEN

RD. SILVER

29d. Date signed (Month, Day, Year)

SPRING ND 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARIA CHRISTINE STIGLIANO 09727/2012 6:53 а. <sub>м</sub> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST CENTER TOWSON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 146-36-3670 (Month, Day, Year Country 1 □ M 2 🖔 F Director 65 01/21/1947 NEW JERSEY er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HORRY MURRELLS INLET 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 554 WESTHAM DRIVE USA 29576 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0036 WHITE 3 Divorced 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 2 YEARS RETAIL SALES Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked ot THOMAS JOSEPH PRINCIPAL JULIA ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. BRUCE H. CAVNOR, JR./SON 1818 EAST MADISON ST. APT 515 SEATTLE, WA 98122 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State PEQUEST UNION CEMETERY 7/31/2012 GREAT MEADOWS, NJ 4 Donation 5 Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 27286 21. Signature of Funeral Service Licensee MO0217 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dancreatic Cancer disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month P.0. Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate rs after dearn.
rai Director. After this cerum. 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other:
4 \(\text{\text{Nursing Home}}\) 1 Residence 6 \(\text{\text{D}}\) Other (Specify) \(\text{VOS} \) ( 1 Yes မ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Anatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my en Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAW J CHANUS M) 6701 A - Clum Completed ST JUHANUES M) 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month 12:55 AM atRICIA Hnne 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore GILCHRIST TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 225-48-8935 **Director** 1 M 2 KF 05 02 Usual Residence of Decedent of Health end Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be mutified at 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland Director Baltimore 1 X Yes 2 ☐ No MO 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 21212 USA raddock 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 27 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) College (1-4 or 5+) ERIPIER Administration 12 2 Be permit. Pege 1 and 2 should be filed. Department of Health end Mental Himportant: If item 27 is more any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ GIPSON ula *younger* 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md. 21212 ddock Powell (Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Baltimore, Md GARRISON FO/esT 4 Donation 5 Other (Specify) QUEHN GREENE FUNELAL SCUS Signature of Funeral Service License 22. Name and Address of Facility Road. Baltimore, Md. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kuncutza Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 24 hours after death. Funder this certificate has been signed by the attending physicien end in Funeral Director. After this certificate has been signed by the attending physicien end Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗗 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIES TOWSON MO 0701 No

Registrar

31. Date filed (Month, Day,

30

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23711 Per PHY G929 //30/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 20:33 PM KAY SINGER JUL 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1**7** M 2□F Months Days Hours March 14,1930 Ohio Director 235-54-3600 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r then "natural", or items 23s or 28s-f show the Medical Examiner must be nutified at 1 ☐ Yes 2 No Baltimore Co. MD Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7956 Bank Street United States 21224 within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▼ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2♥ No Specify: Specify þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed w. \*\* Hygiene. \*\* \*\* Ar then "p. Elementary/Secondary (0-12) College (1-4or 5+) Security Security Guard 12 should be filed w n and Mental Hygier 7 is marked other ti 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma Mannon Herschel Singer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m eny injury or other treum once. 7956 Bank Street Baltimore, Maryland Mrs. Mildred L. Singer(Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 7/24/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mark Williams 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part. Enter the disestance of chiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nours disease or condition resulting in death) . Intracerebral nemorrhage /Medical Due to (or as a consequence of): Examiner 4 years Metastatic was concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner certifica e be executed burial-transit and resulting in death) Last Due to (or as a consequence of): attending physicien Physician/Medical the JSB as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident after death 6 ☐ Could not be 3 🗀 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aff To the Funeral Di completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JULY 22, 2012 RES-000 Maria Cettomai, MD

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

68760

Box

Division of Vital Records, P.O.

State Registrar

31. Date filed (Month, Day, Year) 3 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEANNA CETTOMAT, MD 4940 EASTERN AVE, BALTIMORE, MD 21224 32. Registrar's Signature

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2012 = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 1:20 P M Aboud Bahjat Shakarji Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5533 Charles Street Bethesda Montgomery 8. Date of Birth
(Month, Day, Year)
Jan.01, 1967 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days 1 XM 2 □ F Months Hours Lebanon Director 45 212-96-4917 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 No Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? by Funeral filed within 72 hours after death with U.S. 20814 5533 Charles Street Α. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Shoe and Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Manager Leather Repair Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) မှ Bahjat Shakarji Alice Hajjar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline C. Kamel/Sister McKinley Street, Vienna, Virginia 22180 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, X Burial 2 Cremation 3 Removal from State National Memorial Park 7/21/2012 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Funeral Home, Inc. Gary R. Downer CCO 508 171 W. Maple Ave., Vienna, Virginia 22180-9998 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) 5/11 9 Months Gastric Cancer Medical Due to (or as a consequence of): Examiner Intestinal Psuedoobstruction Month Sequentially list conditions, Examine If any leading to immedic cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ atter in the past 12 months? Month Pregnant at time of death Yes 2 No s been signed by the selected should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy erform death? 2X□ No 1 ☐ Yes 2X No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐XNo ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural work?
1 Yes 2 No injury 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D0065631 25112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9406 Old Georgetown Road, Bethesda, Maryland 20814 Naveen Gupta, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State 3 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ eoPolDina 7.14 A. M 07 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHARLES HARFORD If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign 82-18-1764 Director 1 🗆 M 2 💢 F 88 -15-1923 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits **Funeral Director** notified 28a-f 1 XYes 2 □ No HARFORD HALLSTON 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? must be 23a 21047 HARLES treet items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No 11. Marital Status 14. Race - American Indian, "natural", or iter edical Examiner Black, White, etc. o. Ş 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Yes 2
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MFG worker IQUOR 19 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MICHAEL VOLK Meresa KANKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) ST. Dennis HARLES FAUSTEN MO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rematory 7-26-2012 Battimore ind View 4 ☐ Donation 5 ☐ Other (Specify) 2134 WILLEW Spring Signature of Funeral Service Licensee 22. Name and Address of Facility ASHIDDF. H.P.A. BALLIMORE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between OMACH Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \sum \) Nursing Home 5 \( \text{Residence 6 } \sum \) Other (Specify) Hospital: ပ 1  $\square$  Yes 2 [ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manger of Death 28b. Time of Certificate: 28c. Injury at injury 5 Pending Natural work? Accident 2 🗌 No Investigation 6 Could not be Suicide 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) eath (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O7 Physician/ 4:25 AM Derski mel 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DRIVE Baltimore DUNDALK 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral 7. Age (In yrs. last birthday) 1 M 2 F (Month, Day, Yes Director Usual Residence of Decedent show 10a State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Funeral Director Yes 2 No DUNDALK actimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? SA DRIVE 21222 permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ₩ Widowed 4 □ Divorced Specify. While Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PATETERIA WORKER 12 Public Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FLOWERS Flowers LARA 19a. Informant's Name/Relationship (Type, Print) (Daush) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dene MD 21222 20a. Method of Disposition 20b. Place of Disposition Name of cemetery, crematory or other p 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot or other place) Burial 2 Cremation 3 Removal from State BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 31-2012 of Funeral Service Lice Signature 2134 Willow SPRING, RD. MD ZIZZZ Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury and that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has page 2 performed After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the ca ause of death (Item 23a) (Type, Print) 4920 Campbell Blud, Baltimore

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:00 20 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai Hospital a Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min. (Month, Day, 1 X M 2 □ F **Director** 055 16 1072 VEW YORK 10a. State 10b. County 10c. City, Town or Location an "naturel", or items 23e or 28a-f sho Medical Examiner must be notified at death with the Maryland Directo 1 Yes 2 □ No MO 10e. Street and Number 10g. Citizen of What Country? 21784 Funera HIRN SA 12. Was Decedent Ever in U.S. Armed Forces? 1 bd Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", any Injury or other traumatic event, t<u>he Medical Exa</u> Specify: WHITE 3 N Widowed 4 □ Divorced Baltimore, Maryland 21215-003 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) ECTRICIAN MION LOCAL#3 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WINFIELD, MO DUTH CAMOIL 2012 permit. Signature of Funeral Service Licensee ZUMBRUN EH & MON CO. HUE RO FLIDERSBURG-MO 21784 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced dementia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Yes 2 No q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specification) 2 No rosa,ce Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marriner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD D7033 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) Aue, Battimore un Zhou W Bel vedere m 2121 OVE 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $24^{\mathsf{Day}}$ July 2012 Ruth Six 7:31 A M Lynn Repp Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing & Rehabilitation Ctr. Taneytown Carroll Social Security Number Age (In yrs, last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Sep. 12 9. Birthplace (State or Foreign **Funeral** Months Year) 1915 1 □ M 2 🕱 F Days Hours Director 217-48-3639 96 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Director 1 Yes 2 X No Maryland Carroll Keymar 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 550 Johnsville Rd. 21757 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black White, etc. ò 2 1 Never Married 2 Married ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: 'natural", Specify. 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Cleveland Wayne Repp Edith Clara Lynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Stuart E. Six/ son 2308 Old New Windsor Pike New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Union Cemetery 7/27/2012 Keysville, MD 21. Signatur of Fundal Service License 22. Name and Address of Facility Hartzler Funeral Home, P.A. atharine Broadway Union Bridge, MD 21791 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Prosician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached 1 ☐ Yes 2 € 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🎖 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law hin 24 hours after death. page 2 autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

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completed fi 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryland		irtment of H tificate of D			ene g. No. 2 (	112	24092	
ı	1. Decedent's Name (First, Middle, Last)  Physician/  Kunneth				(	Smith		2. Date of Death Month	Day 18 2	Year	3. Time of Death	
		Medical Examiner  4a. Facility Name (if not institution, give street and number)				4b. City, Town, or	Location of Death	2019	4c. County	of Death	f Death	
	Firmonal		John Hopkins  5. Social Security Number   6. Sex	7. Age (In yrs. last)	birthdav)	Balt:	imore If Under 24 Hrs.	8. Date of Birth	N/A	N/A  9. Birthplace (State or		
	Director 213-60-2296				Yrs.	Months Days	Hours Min.	(Month, Day, 1)		Mar	yland	
	and show dat	tor	Usual Residence of Decedent  10a. State  10b. County	10c. City, To	own or Loc					10	0d. Inside City Limits	
	e Maryl 28a-f notifie	Director	MD N/A  10e. Street and Number			Ba 10f. Zip Code	altimor		g. Citizen of V	What Cours	1X Yes 2 □ No	
	with the 23a or 1st be r	Funeral [	11 W. 20th St. A	pt 710		212	18		U.S.A		uyr	
936	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merital Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1  Never Married 2  Married  3  Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If	Vas Decedent of His Yes, specify Cubar	i, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Blac	e - America k, White, e Bla	etc.	
21215-0036	2 hours "natur edical I	Completed	15. Decedent's Educ (Specify only highest grade	ation 1	(Give k	ent's Usual Occupa	6b. Kind of Bu	b. Kind of Business/Industry				
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pue	be filed ental Hygred rked other ic event,	To Be	17. Father's Name (First, Middle, Last) Paul Albert Smi	th.			÷)					
Maryland	should be file n and Mental H 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type,		19b. Mailin			Mae Jac  al Route Number, (	ity or Town, State, Zip Code)			
	and 2 sh Health a em 27 is ther tra		Paulette Smith(s			Kirk A	<del></del>		-			
Baltimore,	permit. Page 1 and Department of Hea Important. If item any injury or other once.		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other place Cremato			altimo			
Balt	permit. Page 1 Department of Important: If any injury or once.		21. Signature Funeral Service Licensee	i Kar	3°	овернон 140 N. I	of Brown Fulton	Jr. Fu Ave., B	neral altimo	Home	e PA MD21217	
	Trans. Sunch		23a. Part 1. Enter the disease, or complications, or heart failure. List only one of immediate Cause (Final	omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line.							Approximate Interval Between Onset and Death	
ŝ	Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):									
	Examiner	er	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consequen	)ia							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Uisease or injury that initiated events	<u>hepatocel</u>	2 1	curcin	sma_					
_	ate be executed physician and the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consequen	ice of):							
8760	ifficate ng phys as the		IF FEMALE:									
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and for the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	c. If yes, outcome of pregnance  1  Live Birth 2  Fetal d  4  Pregnant at time of dea  9  Unknown	eath 3	Ectopic pregnanc Other (specify)	у			3d. Date of delivery Month Day Year		
ds, P.O.	quires that the series of signed by and be deta	by	Part II. Other significant conditions controlled to hepartocally la			en in Part I. 🎽		id tobacco use contribute to the cause of dea				
Records,	The law recate has be page 2 she	Completed	HIV							24a. Was an autopsy findings prior to completion of death?  1  Yes 2 No 1 Yes 2 No		
of Vital	/sician s certifi directo	To Be										
on of	nding Phy ath. : After thi e funeral		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		jury 28b. Time of 28c. Injury at			28d. Describe how injury occurred				
Division	al or Atte s after des l Directol d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office			f. Location (Street and Number or Rural Route Number, City or Town, State)			
J	ne Hospit: n 24 hours ie Funera bletely fille	Medical	(Check 2 Medical Examine)	: On the basis of examination a	nd/or invest	tigation, in my opinio	n, death occurred a	it the time, date and	due to the cause(s) and manner as stated. e time, date and place, and due to the cause(s) and and due to the cause(s) and manner as stated.			
	To the within Comp		29b. Signature and title of certifier			29c, License	29	d. Date signe	_			
D				mpleted cause of death (Item 20	_		5 - 000		2017	18'	2012	
<u> </u>			Erik Ver	zemnieks	MI							
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	barke	1						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Physician/ 0<sup>Month</sup> 2012 10:45 AM Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1734 Bolton St. Baltimore N/A Apt If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Month, Day, 280-38-1960 Kentucky Director Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified N/A 1 X Yes 2 No MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1734 Bolton St. Apt1 21217 U.S.A. 'natural", or items Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: Completed 3 - Widowed 4 Divorced Black A and Mental Hygiene.

27 is marked other than "natural" Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) R. Estate Self years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James W. Miller Sr. Ollie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Pullian(sister) 2224 Eutaw Place 1st Fl., Baltimore, MD21217 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory Baltimore, MD Signature of Funeral Service Licensee josephorns Brown Jr. 140 N. Fulton Ave., Funeral Home, Baltimore, 21217 294. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line immediate Cause (Final ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Cause (Disease or linjury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) the g Unknown þ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe page 2 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Tes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 3 Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and admess of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

3 0 2012

32. Registrar's Signatur

1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Leona Margaret Wilson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death FRANKLIN Square Hospital Rosedal Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 7. Age (In yrs. last birthday) Months Min 213 12 9971 90 **Director** 1 □ M 2 🔀 F July 18,1922 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location the Maryland Director notified 28a-f Baltimore Maryland Essex 10e. Street and Number ö 10f. Zip Code ms 23a or must be Funeral with 1 5 Brett Ct. Apt. 316 USA 21221 items 2 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No ò þ 1 Never Married 2 Married filed within 72 hours after 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 02 "natural", 3 🛮 Widowed 4 🗆 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Production Worker and Mental Hygier is marked other traumatic event, the Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) ပ Charles Mattes Mary Helinski and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1711 Melbourne Rd. Baltimore, Maryland 21222 Patricia M. Branamen (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc. 7/31/2012 21. Signature of Funeral Service Licens <sup>22. Name and Address of Facility</sup> Bruzdzinski Funeral Home P.A. 1407 Old <u>Fastern</u> Avenue Essex eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cardio disease or condition pulmonary Medical resulting in death) Due to (or as a consequence of) Examiner A-Fib Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam apid ventricular that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but Disease Coronar Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> Completed 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 . No မ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending iniury Investigation Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifie 29c. License number 7274 Chehab 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cheha

32. Registrar's Signature

Rafik

ma

31. Date filed (Month, Day, Year) **30 2012** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

20 p M 2012 4c. County of Death LTIMORE Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Shoe Mfq. 18. Mother's Name (First, Middle, Maiden Surname) 20c. Location - City or Town, State Baltimore, Maryland Maryland 21221 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 29d. Date signed (Month, Day, Year, 9000 FRANKLIN SQUARE DR Balto Md

3. Time of Death

Voor

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1044 AM Physician/ WILSON Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL SAMARITAN BATMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours 3020 **Director** 1 🗆 M 2 🔀 F 88 Yrs. 12-24-1923 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at BaltiMORE MD 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral HILLTOP AVENUE 21206 USA items ? permit, Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Il Hygiene. Lother than "natural", or iter vent, the Medical Examiner 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) STERILIZER inversity of TECH of Health and Mental Hygitem 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 David Darden 19b. Mailing Address (Street and Number or ural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) Department of Heatth ar Important: If item 27 is any injury or other trau once. HILLTOP AVE. BALTIMORE, Md. 21206 ames 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GREENE FUNERAL SCH 21. Signature of Funeral Source Licenses BAUTIMORE, Md. 21212 ROAd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between nset and Death Immediate Cause (Final Physician/ PNEUMONIA Houes disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ENTRAPPED Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) -transit and that initiated events resulting in death) Last Due to (or as a consequence of) the burialcertificate has been signed by the attending physician lirector, page 2 should be detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 1 ☐ Yes ∠ L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? ( GORONARY HEART DISEASE) 24a. Was an 1 Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☐ No Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatu RES 00

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Registrar
DHMH 17 Rev 06-2011

LOCH RANGN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fyten MD 56 91

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day WINSTON RENCE Mon 21 4:47 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY HOW ARD GENERAL HOSPITA COLUMBIA Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Feb 15, 1930 Days Months Hours Min. 026-28-3584 82 MA Director 1 M 2 □ F Usual Residence of Decedent Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinating that be motified int 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Howard 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5400 Vantage Point Rd. #712 21044 U.S.A. death o 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever III C.S. Armed Forces? 1951
1 X Yes 2 No 195
If Yes, Give Year or Dates. No Can Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Management Clothing Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F **Hyman Winston** Esther Levin permit. Pege 1 end 2 should be Department of Health and Ment Important: If Item 27 is marke: any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11860 Burnt Passage Columbia, MD 21044 Jill Lapides Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) cemetery, crematory or other place)
Lakemont Memorial Gardens Jul 30, 2012 Davidsonville, MD 21. Sign turn of Fundal Solvice Lice 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MOOS 34 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a nsequence of): **€**xaminer VOLVULUS Moid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ettending physician end I for use es the burial-transit Exami To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 1 No 1 Yes 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my original death occurred. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Sign ho completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day,

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Philip Adam Aksomitus 30 VIIV. 20°12 04:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hart Heritage Estates Harford Street Social Security Number 9. Birthplace (State or Foreign Country) Inkerman, If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Rirth **Funeral** 1 🕅 M 2 🗆 F Days May 15, 1932 201-24-5052 80 Director Usual Residence of Decedent 28a-f show 10a. State 10h County ral", or items 23a or 28a-f shor Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 D. Kimary Ct. 21050 U.S.A. should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White "natural", 1958 Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. arked other than Elementary/Seconday (0-12) College (1-4 or 5+) Pipe Fitter Bethlehem Steel 12 Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ၉ Joseph L. Aksomitus Alice Gatch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is Mr. John L. Aksamitus (San) 709 Heston Ct., Bel Air, Maryland 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 01, Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Rosedale, Maryland Cardens of Faith Cemetery 2012 Signature of Funeral Service Licensee Jeffrey R. 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Pel Air <u> 3 Newport Drive, Forest Hill, Maryland 21050</u> 23a. Part Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freat failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death DILLASE erebral Vascular Promiciani disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): -transit and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical certificate be Box 68760 the ast the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown s been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law this certificate has page 2 performed 2 No Yes 2 N 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ည CAM 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannet of Death 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 20/2 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BelAIN MALPHAI 615 W. MA 31. Date filed (Month, Day, Year, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ ROLAND ALSTON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Northwest Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 11-25-54 Country) Director 215-60-5883 57 1 X M 2 □ F MD Usual Residence of Decedent en "netural", or Items 23a or 28a-f show Medical Evaminer must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. NA Baltimore 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 N. Fremont Avenue 21201 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. African 1XX Never Married 2 ☐ Married ρ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: American 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) NA 12th Grade Johns Hopkins Hospital Electrician 27 Is marked othe traumatic event, Be ath and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ruth Ε. Alston Roland Stewart I and 2 should b f Health and Me Item 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 22 Swanbridge Court Baltimore, Maryland 21244 Ruth Alston-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20c. Location - City or Town, State Date . Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-03-12 Owings Mills, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lisense 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of yone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, neumowia Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burlal-transit or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Year ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has perform 2 [ 1 Yes 2 🗆 No filled in by the funeral director, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🕩 Other See Hospital: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2012 рΜ Physician/ 12 July Anthony Alimo, Jr. Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Towson Hospice Gilchrist If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min (Month, Day, Year) Months 217-04-3058 Director 1 🕅 M 2 🗆 F Yrs. 46 June 17, 1966 Maryland Usual Residence of Decede 10d. Inside City Limits 28a-f show 10c. City. Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Owings Mills Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21117 10 Allspice Court Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☑ Yes 2 ☐ No If Yes, Give 1 X Never Married 2 Married ۾ should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or 1 ☐ Yes 2 🛣 No Specify: Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Auto Dealership Service Writer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ellen Μ. Lane Joseph Anthony Alimo, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau once. Owings Mills, MD 10 Allspice Court Ellen M. Moses Mother Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State 8/3/2012 Reisterstown, MD Saints Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road 21136 ensins Reisterstown, MD Ne ELINE FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Dram Physician/ disease or condition resulting in death) Jumps Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of): Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months?

1 Yes 2 No
9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?
☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 24 hours after death. Funeral Director: After 1XX Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) Signature and title of certifier D0071287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Philip Shaheen, 6701 N. Challes St. # 4105, Baltinge, MD 212 04 32. Registrar's Signatura 31. Date filed (Month, Day, Y State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Akehurst Month Physician/ Eleunor 4:50 A M 27 JULY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Steven Drive Edgewood Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Hours Director 1 □ M 2 🗓 F <u>342-18-764</u>1 89 Jan. 23,1923 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Eventiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Harford Edgewood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1831 Steven Drive 21040 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. 1 Yes 2XX No If Yes, Give 1 ☐ Never Married 2 🔀 Married þ Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th. Grade Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **Fuller** Julia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Drive, Edgewood MD Clifton Akehurst/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial XXX Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 07/28/2012 Glen Burnie 21. Si nature of Fur eral Service Lice e <sup>22</sup> Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Rd., Bel Air MD 21014 23a. Part 1. Enter the dise shock, or heart failur Immediate Cause (Final se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cust only one cause on each line. Approximate Interval Between Onset and Death multiple myeloma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physiclan and I for use es the buriel-transit Exami The lew requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I s been signed to should be det 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed2 Yes 2 ☐ No eral Director: After this certificate filled in by the funeral director, pag 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) é 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending hours after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Funel completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

MS Ruy Apall MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 703 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of M	1arylan					and M			711	12	24	0
Registrar  1. Decedent's Name (First, Mid.				rst, Middle, Last	·)	uncai	ificate of Death					o. — •		3. Time of D	)eath		
	Physician/					July					Month 26, Day 2012 ear			12:10			
Medical Examiner  4a. Facility Name (if not institution, give s						4b. City	4b. City, Town, or Location of Death				4c. County of De						
No. of Street, or other Persons			Charlestown Nu						onsvil				Baltimor			e	
	Funeral 5. Social Security Number 6. Sex  Director 220-09-8188 1 \[ \text{M} \text{N} \text{Q} \text{F}					7. Age (In yrs. last birthday)  92 Yrs.			If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.			8. Date of Birl (Month, Da July 28	h y, Year) <b>, 1</b> 9				Foreign
	show at	5	Usual Residence of De 10a. State 10a	o. County		10c. Cit	y, Town or Loc	cation	1						10	d. Inside City	Limits
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	72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho fedical Examiner must be notified at		10e. Street and Number					10f. Zi	p Code				10g. C	itizen of Wha		ry?	
		Funeral	715 Maiden Ch							21228				U.S.A	•		
	r deat or iten iiner i		<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li></ul>		12. Was Decedent Armed Forces	?	S. 13. V	Vas Dece f Yes, spe	dent of Hi	spanic Orig n, Mexican	gin? (Spe ı, Puerto	cify Yes or No- Rican, etc.)		14. Race - / Black, V			
036	s afte ral", c Exam	d by	3   Widowed 4 □	If Yes, Give Year or Dates.				☐ Yes 2 🗷 No Specify:					Specify:	White	2		
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2	hin 72 ne. than ' e Me	mo	Elementary/Seconda		College (1-4 or	5+)	life. Do	O NOT us	e retired)	_	OrWORK		D. 1.	·	- C		
2	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be C	17. Father's Name (First.	Middle Last)	N/A		Secret	ary/l	reasu		orla Name	e (First, Middle,			erri	geration	
Maryland		인	William	, Middle, Edoty		Ric	ordan			Joha:		; (FIISI, MIGGIE,		Morriss	ey		
ary			19a. Informant's Name/	Relationship (Typ	oe, Print)		19b. Mailin	ıg Addres	s (Street a	and Numbe	er or Rura	l Route Numbe	r, City o	r Тоwп, State	e, Zip Co	ode)	
			Clark Adams,							rive P	asade	na, Mary	Land	21122			
ore			20a. Method of Disposit 1 D Burial 2 D C		Removal from State	e c	Place of Dispo cemetery, crem	natory or	other place	e)	_	Date		ocation - Cit	•		
Baltimore,			4 Donation 5	-		NEETE CH	xdlawn Ce		<u> </u>			/2012		imore,		Land —————	
Ba			21. Signature of Funeral	S. Ost	much							1 Home, I dena, Mai		d 21122			
والمتحدد			shock, or heart failure. List only off-grause on each line.											Approximate Interval Betwe Onset and De			
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687	Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:	. 2	23c. If yes, outcome	e of pregna	ıncv							22 1 5 1	5 d d		
Вох		iciar	23b. Was decedent preg in the past 12 mon 1 Yes 2	ths?	1 ☐ Live Birth 4 ☐ Pregnant	2 Feta	al death 3	Ectopic Other (s		у				23d. Date o Month		y Day Yea	ar
Э.	hat the dea ed by the a detached f	hysi	g Unknown														
P.0	es that I signed b	by P									l.	23e. Did to	bacco	o use contribute to the cause of death?			
ds,	requires been sig should b	ted								1 ☐ Yes 2 ☐ No 3 ☐					Proba	ably 4 Ur	ıknown
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ita	ysician: The is certificate director, pag	Be	25. Was case referred to examiner?  1  Yes 2  No.	To.	łospital:				Otho	r /	of Death (Check only one)						
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	≥ <b>≃</b> ర	Dun M. Buttoword, CRNP ROGZ382									26-1		ay, roury				
			30. Name and address of	of person who co	ompleted cause of	death (Item	23a) (Type, P	rint)									
)			AnnM.B	outterw	iorsh, cr	NP 7	109 M	a ide	nche	العال	one	Balto	Me	1213	328	3	
	Sta Registra		31. Date filed (Month, Da		32. Regist	rar's Signa	ture										
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death July <sup>Day</sup> 2012 Physician/ 1:45 PM M 19 Gilbert Lee Ballinger Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Centreville Oueen Annes 617 Clarks Corner Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours 85 Director 225-20-3227 May 10, 1927 Virginia Usual Residence of Decedent show 10d. Inside City Limits 10c. City. Town or Location 10a. State with the Maryland Director must be notified 1 🗆 Yes 2 🔀 No 28a-f Queen Annes Centreville MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21617 23a Funeral 617 Clarks Corner Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 14. Race - American Indian, 2. Was Decedent Ever in U.S. ıral", or iten Examiner r med Forces?
No 1945þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: Specify: white 'natural", Completed 3 X Widowed 4 Divorced 1947 Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the financial accountant 12 of Health and Mental Hygie If item 27 is marked other in other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Kate Lee McCabe Harold Odell Ballinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 617 Clarks Corner Rd; Centreville, MD 21617 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If item 27 is 7 or other tra Wayne Ballinger - son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Ronal d S. Wane, Director 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, i ian disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of). it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed page 2 25. Was case referred to 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature 10" SPREN RE CAESTERTOW MD 21620 30. Name and address of person who completed cause of death (Item 23a) (Type

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 29D, PER MD G929 7/31/12 TRT.

State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0010 AM **Physician** mai /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE BRADFORD Oak GEORGE ENTER CLINTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months 1 □ M 2 🗹 F unk 410 86 23 63 Usual Residence of Decedent Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County •how a 23a or 28a-f ehorust be notified at 1 ☐ Yes 2 ☐ No Clinton Prince George's Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20720 7520 Surratts Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: r than "natural", or Itema 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black þ 3K Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk College (1-4or 5+) ntal Hygiene. ed other than event, the Ma Elementary/Secondary (0-12) unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk unk . Pages 1 and 2 should be fill timent of Health and Mental Hitant: If Item 27 is marked oth jury or other traumatic eventions. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Clinton, MD 20729 Date 20c. Location - City or Town, State Bradford Oaks Center 7520 Surratts Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition permit. Pages 1
Department of F
Important: If its
any injury or of 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 ☑ Other (Specify) in state 21. Signature de Fineral Service Lica see 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Dementia Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached O 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 ☐ Yes 2 SNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 🔀 No Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred the funeral 28b. Time of 27. Manner of Death Certification: After Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide in by determined 4 Homicide Hospital or within 24 hours a To the Funeral C 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (ane & 7/27/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingen Road Fut WASHigh TANNER MY William 1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $\overset{\text{Day}}{2}\underline{012}$ July Physician/ Steven Beane 11:10pMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center Howard County Howard Columbia . Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Age (In yrs. last birthday) 56 Yrs. **Funeral** 9. Birthplace (State or Foreign May 7, Day 1936 1**X** M 2 □ F Vi<u>rginia</u> 215-66-9527 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Beltsville Maryland | Prince Georges 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3901 Lakehouse Road Apt#15 20705 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Homecrest Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edwin Willard Beane Helen Mae Slusher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to Gail Beane/ wife 3901 <u>Lakehouse Road Apt#15, Beltsville, MD. 20705</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 07/30/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of MAryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CANCER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ophogeal concer And Tonsillar concer, Records, 1 Yes 2 No 3 Probably 4 Unknown Atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Division of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending the Funeral Director. Aft 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 0 25205 Thorn 30. Name and address of person who complete ed cause of death (Jum 23a) (Type, Print) 5 N. Charles St. Balto. md 6701 BMC State Registrar

09/89

Box (

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 🤈 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July George William Barber, Sr. 2012 $P^{M}$ 06:54 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1637 Trappe Church Road Harford Darlington Social Security Number 9. Birthplace (State or Foreign Country) Baltimore Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth **Funeral** Month Day, Year) Sept. 12, 1921 1 🗶 M 2 🗆 F 215-12-7336 90 Director Usual Residence of Decedent 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1637 Trappe Church Road 21034 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1942— If Yes, Give 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 1945 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Owner - Middlesex Electronics Comunications/ Entertain 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard F. Barber Mary E. Chaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Mr. George Barber, Jr. (Son) 1435 Sharon Acres Road, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other old Evans Funeral Chapel Bel Air 1 Burial 2 X Cremation 3 Removal from State July 28, 2012 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee Jeffrey R. 22. Name and Address of Facility. Evans Funeral Chapel & Cremation Services - Bel Air Salley 3 Newport Drive, Forest Hill, Maryland 21050 23a. Pal tree the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, orb, art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition YITIMA Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year signed by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 Yes 2 No Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural Accident Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide after determined City or Town, State within 24 hours a Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year, completed cause of death (Item 23a) (Type, Print) W

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 30 2012 Physician/ Betty Love Benn 1:20 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Symphony Manor Assisted Living Baltimore 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month. Months Days Hours (Month, Day, Year) April 29, 1925 239-30-0541 North Carolina Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore 1 X Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral U.S.A. 21210 4301 Roland Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11 Marital Status Armed Forces Black, White, etc. o. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 72 hours after white If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 ₩ Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Executive Research Business Owner or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Lou Rutledge Charles Oscar Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 1361 Vista Moreda Santa Fe, New Mexico 87506 sister Peggy Love Day 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Aug 7 2012 Winston Salem, N.C. 4 Donation 5 Other (Specify) Forsyth Memorial Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home In 6500 York Road Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ementa Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence on. and -transit Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial physician s the burial Physician/Medical Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown signed by the a d be detached f Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by obstructive lung disense 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been Transievi ischemic Attacks 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has I autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSisted Live Hospital 1 ☐ Yes 2 12 No Other: 4 Nursing Home 5 Residence 6 Other (Sp မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural work 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Ken 30 Name and address of person 701 N. Charles St. Beelto.

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JuMenth 19, 29012 8:45 PMM William Barnes Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's 2703 Oxon Run Drive Temple Hills Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 249-52-4421 **Director** 1 X M 2 - F 77 Feb. 22, 1935 South Carolina Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 X No MD Prince George Temple Hills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2703 Oxon Run Drive 20748 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 5 þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2K No Specify. "natural", 3 Divorced 4 Divorced Specify: Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 6 Janitorial Housing Units Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Leroy Barnes Lou Ingram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Martha Ann Barnes - Wife 2703 Oxon Run Drive, Temple Hills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State New Hope AME Zion Cemetery ★Burial 2 ☐ Cremation 3 ☐ Removal from State 7-28-2012 4 Donation 5 Other (Specify) Lancaster, SC Signature of uneral Service Licenseq Metropolitan Funeral Service 22. Name and Address of Facility 5517 Vine Street, Alexandria, VA Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or neart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final metastatic Colon Concer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 Unknown the signed by Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' after death.

Director: After this certificate 2 No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖃 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 No Investigation 6 Could not be within 24 hours after death

To the Funeral Director: / Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D5068 6

State Registrar River

MINOSITA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHHABRA

Laurnter S.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 10:35 Cheryl Marie Bauer 07 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months Hours Director 1 - M 2 1 F 214-76-0580 55 01/26/1957 Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show numatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 Days End Court 21237 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married δ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Broker Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Ferdinand Louis Bauer Irene\_Telal 19a. Informant's Name/Relationship (Type, Print) 2012 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane I. Abate / Sister 20 Days End Court, Baltimore, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/28/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall 1 Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition OVARIAN CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examine Due to (or as a consequence of): burial-transi Due to (or as a consequence of): resulting in death) Last igned by the attending physician be detached for use as the bunk Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day 1 ☐ Yes 2 🕱 No g ☐ Unknown g 🗌 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I **Division of Vital** 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) **HOSPICE** 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and tij 29d. Date/signed Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Boone Physician/ 545PM enette 105 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Future Care Pineview Nursing Home Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Min. 578 70 4549 Director 1 □ M 2 XX 57 Aug 7, 1954 Washington DC Usual Residence of Decedent 27 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗌 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11517 Scotch Hills Place 20602 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 TNo If Yes, Give X Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Adm. Officer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clinton Marietta Wiggins permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole Boone (Daughter) 11517 Scotch Hills Place, Waldorf. MD 20602 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XX Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 29, 2012 Clinton, MD Lee Crematory 21. Signature Junoral Service icensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MO 13 Ferry Road, Clinton, MD 20735 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ₽hysician/ ncephalopa disease or condition resulting in death) Medical Due to (or as a consequence of): aminer rebrovascular Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mmunodeliciena 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 PN To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 11/No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: I or Attending F after death. 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital c 24 hours at Funeral D Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. heck Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I officertifie 29d. Date signed (Month, Day, Year) 252012 person who completed cause of death (Item 23a) (Type, Print) Name and address 9106 Pineview

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

31

32. Registrar's Signature

Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transi physician Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

Physician/

Examiner

Funeral

**Director** 

28a-f show

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at

nd Mental Hygiene. marked other than

and is m

permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra

Physician/

Medical

filed within 72 hours after death

Page 1 and 2 should be

Baltimore, Maryland 21215-0036

Medical

Director

Funeral

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Completed

Be

မ

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown		23d. Date of delivery Month Day Year					
Part II. Other significant conditions	contributing to death but not resulting in the unc			use contribute to the cause of death?			
DIABETES MELLY	tus type II Hyper	TENSION	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 ☒ No			
25. Was case referred to medical		26. Place of Death (Check only one)					
examiner? 1  Yes 2  No	Hospital: 1 M Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury		28d. Describe how inj	ury occurred			
3 Suicide 6 Could not 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
(Obsert O Medical Ever	nysician: To the best of my knowledge, death oc miner: On the basis of examination and/or investig urse Practioner: To the best of my knowledge, de	ation in my opinion, death occurred a	t the time, date and pia	ce, and due to the cause(s) and mariner stated.			
29b. Signature and title of certifier	that no	29c. License number  RES 001		Date signed ( <i>Month, Day, Year</i> )			

BALTIMOKE MD 21225

S. HANOVER

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

3001

32. Registrar's Signature

CRAIG M. HOLT

31. Date filed (Month, Day,

JUL 3 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ETER RENSON 12:20 AM JUSTPH UL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death COUNTY GENERAL ITOSP MARION Cowmsia Honno Social Security Number 9. Birthplace (State or Foreign Country) Fingland 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 . F Days Hours January 22,1954 **Director** 216<del>-</del>98-2415 Usual Residence of Decedent 28a-f show items 23a or 28a-f sho ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 N/A 10627 High Beam Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black, White, etc 0 1 Never Married 2 X Married þ within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ould be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Singer/Song Writer/Performer Entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peggy Coulter Joseph Benson and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 i Karen Keane (Wife) 10627 High Beam Court Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-3-2012 Atlantic Crematory Glen Burnie, Maryland 21. Signature of Fune al Service Lin nsee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ METASTATIC ITEMO AND WELK Medical resulting in death) Due to (or as a consequence of): Examiner SQUAMOUS CERL Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): bunial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician are as the bunal Physician/Medical certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ atter in the past 12 months?
1 Yes 2 No
9 Unknown Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TRAZUEDEN HAZEAL RSTULA Division of Vital Records, 1 Nes 2 No 3 Probably 4 Unknown Completed OBSTRUCTIVE Purnowney Micias . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Director: After this certificate I in by the funeral director, page 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Beath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 1) 36974 JUL 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 221VB MO 10710 CHANTER COUNTY A MO NYANJOM 20544 0. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

JUL 3 1 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $^{\text{Month}}1y$  26 ay 2012 a Physician/ Lydia Bonhardi 1:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Charlestown Care Center Catonsville Baltimore Social Security Number 8. Date of Birth (Month, Day, Year)
Sept. 20,1917 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Min 216-03-3810 Days Hours 1 🗆 M 2 🕇 F **Director** Ohio 94 Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified Catonsville MT Baltimore 1 Yes 2 K No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21228 709 Maiden Choice Lane 211S USA ral", or items 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 X Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. "natural" Completed 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Mental Hygiene. narked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Transportation U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Fredia Kleinkencht Fred Bonhardi and i 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1945 Gardenia Street; Eldersburg, MD 21784 Page 1 and 2 sh tment of Health a tant: If item 27 is Thomas Bonhardi Nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date cemetery, crematory or other place)
Moreland Mem. Park 1 X Burial 2 Cremation 3 Removal from State 7/31/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee M01050 tadoma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Jupp hour a Medical resulting in death) Due to (or a a consequance of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir the burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral dire 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1- Natural 5 Pending injury work? 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🕊 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number R082382 7-26-12 Dutten CAMP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) md 21228 Ann M. Butterworn CRNP 709 Maidencheice Care Balto.

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

3 1 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. Vity, Town, or Location of Death 4c. County of Death Anne Arundel <u>1513 Feral Dae Lane Unit 102</u> Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Director 216-32-8779 TM 2 DF Yrs 75 June 10, 1937 Virginia Usual Residence of De or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Madical Examiner must he matified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Anne Arundel Annapolis Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21409 1513 Feral Dae Lane Unit 102 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify. Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Koppers Automotive Plant 12 N/A Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Mary Isabelle Jones Jesse Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Feral Dae Lane Unit 102 Annapolis, Maryland 21409 <u>Dorothy L. Barnes (Wife)</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/27/2012 Glen Burnie, Maryland Glen Haven Mem. Pk. 22. Name and Address of Facility
McCully—Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 Signature of Edneral Service Licensee MOO-732 23a. Int 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death Physician/ OBSTRUCTIVE FULHONARY HRONIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 tonknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 LM within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ည 1 Yes 2 🗍 Ne 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. injury at Certificate: 28d. Describe how injury occurred work? Natural injury 5 Pending 2 Accident
3 Suicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Curtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2012 (D) cause th (Item 23 (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death Month. Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millersville Anne Arundel 8264 Railroad Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Mge (In yrs. last birthday) Funeral Days Hours Min (Month, Day, Year) Director 220-24-6668 1 □ M 2 E 83 March 8, 1929 Maryland Usual Residence of Deceden th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Machel Examiner must be notified at 10d. Inside City Limits 10b. Count 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Millersville Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 44 Benson Avenue 21108 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retired) during most of working (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Secondary (0-12) Self Employed Tag & Title Company 1 and 2 should be filed w if Health and Mental Hygi item 27 Is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ E11en Burns Mary Grove Samuel. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8264 Railroad Avenue Millersville, Maryland 21108 Ellen Eileen Prinkey (Daughter) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it ō 1 😿 Burial 2 🗌 Cremation 3 🔲 Removal from State injury 4 Donation 5 Other (Specify) Glen Haven Memorial Park 08/02/2012 Glen Burnie, Maryland 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funetal Service Licensee MOO-732 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ E-BK Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Eue to (or as a consequence of): If any, leading to immediate cause. Enter Underlying Exami ng physician and as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending I IF FEMALE: yes, outcome of pregnancy □ Live Birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Vear 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed l irector, page 2 should be de þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 € 1 \sum Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be data incer examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence 2 [] NO ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗆 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29d. Date signed (Month, Day, Year) 30 ath (Item 23a) (Type, Print) lame and address of person who co 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LYDIA ELIZABETH BENNETT July 24 Physician/ Year 4:05 P M Medical 4a. Facility Name (if not institution, give street and number)
Genesis Healthcare 4b. City, Town, or Location of Death Severna Park 4c. County of Death **Examiner** Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Sept 29 1 M 2 XF Months Days Hours Min. 93 "Maryland 212-14-0821 Director Ĩ918 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", &r items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Balt.imore N/A Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Bloomsberry Street 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife & Mother ad be.
ad Mental Hyg.c.
s marked other th Homemaker 8 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph J. Tolson Goldie Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Shirley Holly 115 Bloomsberry St., Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland 7/27/2012 4 Donation 5 Other (Specify) McCully-Folyniak Funeral Rome, F.A. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility 237 East Patapsco Ave., Baltimore, Maryland 21225-1856 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Dementio Advanced disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immedicause. Enter Underlying or as a consequence of Atria Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 After this certificate has funeral director, page 2. 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 1 only one 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

6095 Marshalee Drive, Elkridge, MD

e of death (Item 23a) (Type, Print)

bar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 Month 20°12 2:38A Morris Delaney Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Gilchrist Baltimore 5. Social Security Number 140-28-7547 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min. (Month, Day, Year) **Director** TM M 2 D F 75 Yrs. 10/29/1936 Maryland er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State irector 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore NO Yes 2 □ No Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 5418 Frankford Estates Dr. 21206 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, was Decedent Ever Armed Forces? 1 2 Yes 2 No If Yes, Give Year or Dates. Black, White, etc 1 Never Married 2 Narried ğ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) 8th Grade Crane Operator Bethlehem Steel age 1 and 2 should be filed wir int of Health and Mental Hygle t: If item 27 is marked other / or other traumatic event, ∰ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pauline Hall Dumas D. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5418 Frankford Estates Dr., Baltimore, MD Lorraine Brown (wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State on-site Crematory (8/03)12-Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 305 phodes Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List only one cause on each line. Approximate Interval Between Onset and Death BLADDER CANCER
PROCERCINOMA Physician/ disease or condition VOAR Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami and I-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physiclan a I for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copfibute to the cause of death? þ ERTENSION Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been sign 24a. Was an 24b. Were autopsy findings available has page 2 autopsy prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No Yes 2 N To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes 2 🗍 No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First Middle 1 ast) 2. Date of Death 3. Time of Death Physician/ Month John Robert Brooks Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Daint Joseph Medical Center Baltimore TOWSOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 212-60-5085 Hours Min Year) Days Director 1**X** M 2 □ F 01/02/1954 58 Maryland 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified N/A Baltimore MD 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 21212 U.S.A. 1053 Upnor Rd. items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) mentary/Secondary (0-12) College (1-4 or 5+) Local 37 12th Grade Heavy Equipment Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dorsey Brooks Lillie Veney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1053 Upnor Rd., Baltimore, MD 21212 Renee A. Brooks(wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State on-site Crematory 🛚 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 30sephodes Brown Jr. Funeral Home PA 21. Signature of Foreral Service Licenses 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** equentially fist conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Yes 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 💢 Yes 2 □ No 3 □ Probably 4 □ Unknown been signated Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy perform death? this certificate Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) \_ 2 🗶 No Other: 4 \( \sum \) Nursing Home \( 5 \sup \) Residence \( 6 \sup \) Other (Specify) 1 Yes 1 X Inpatient 2 🗆 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 \( \subseteq \text{Yes} \) s after death.

I Director: After the full of the full Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Osler Drive rancis lowson Khoo M.D 60 31. Date filed (Mon State 31 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 26<sup>Day</sup> 7:00 P M Physician/ 201<sup>Year</sup> Margaret Berk Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Fallston 2220 Pleasantville Rd. If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 7. Age (In yrs, last birthday) (Month, Day, Year) Days Min 94 215-01-0020 1 □ M 2 X F **Director** 3/19/1918 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Maryland Harford Fallston 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2220 Pleasantville Rd. U.S.A. 21047 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2X No Black White etc. ō 1 Never Married 2 Married by 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White er than "natural", the Medical Exar 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker should be filed with h and Mental Hygien is marked other ti 12 0 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eleanor Albert Joseph Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2220 Pleasantville Rd, Fallston, MD 21047 Marguerite Maricle/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7/30/2012| Baltimore Gardens of Faith 5 Other (Specify) 4 Donation 21. Signature Parkview Funeral Home & Cremation Se 7527 Harford Rd, Parkville, MD 21234 Service ronly 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE Physician CONGESTIVE HEART disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** DISEASE CORONARY ARTERY YEMMS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the 88 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?

1 Yes 2 X No Day Year Month signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Myelodysplastic 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No After this certificate or Attending Physician: after death.

Director: After this certifications funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral D Hospital Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 3 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 V reno 21236 PERNANDO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 3:35 PM 4UW Medical D12 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSATA HOWARD Columbia Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🕅 M 2 🗆 F Days Hours 65 April 9 Director 36-38-8124 New Jersev Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Maryland Howard 1 Yes 2 X No Ellicott City ò 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 23a ( Funeral 3092 Rogers Avenue Apt.A 21043 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 9 ģ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed Specify: white 3 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carlton H. Bauer Vivian O. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leah M.Conelly Bauer/wife 3092 Rogers Avenue Apt.A Ellicott City.MD. 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State metro Crematory, Inc 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/26/2012 Baltimore, Maryland Signature of Fuheral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line CIRRHOSIS Immediate Cause (Final Physician/ disease or condition resulting in death) >10 years Medical Due to (or as a consequence of) Examiner EPATITIS ucan Sequentially list occulificus if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law page 2 autopsy 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes Other: ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident 2 🗆 No Investigation 24 hours after death Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) n who completed cause of death (Item 23a) (Type, Print).

AN, UD HCGIH 5755 ledar Lave Columbia LLD 27044 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

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**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carrie Elizabeth Clifford July 2012 26<sup>Day</sup> 8:55 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Masonic Home Cockeysville Baltimore . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 215-24-6843 Balt. Maryland Director 94 1918 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State Director 10c. City, Town or Location 10d. Inside City Limits Cockeysville Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Completed by Funeral 300 International Circle 21030 America 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates white 3 X Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Musician Instruction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Herbert A. Sandlass Carrie Louise Buchheimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Mrs. Patricia L. Brune/daughter 2 Ballyhean Court Timonium, Maryland 21093 20a, Method of Disposition Jate 31, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 1 🗆 Burial 2 🛭 Cremation 3 🗆 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland of Funeral Service Lice 22. Name and Address, of Facility Peaceful Alternatives Funeral and Cremation Center, P.A any 2325 York Road Timprium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ emen disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year signed by the a d be detached f 1 Yes 2 g 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ cate has been signated bage 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 🗆 No Yes 2 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2. No Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 KNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Accident
Suicide 2 🗆 No Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 John

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

OWIF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G930 8/01/2012 JH. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 30 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital Baltimore Baltimore of If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Hours Min. (Month, Day, Year) 248-74-3608 Director 1 MM 2 🗆 F 4-15-194 68 show 10d. Inside Ony Limits 10b. County 10c. City, Town or Location 10a. State Completed by Funeral Director must be notified imore 28a-f 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? ö 23a USA 2/2/5 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. or i 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-003 3 ☐ Widowed 4 ☑ Divorced "natural", 15/ac other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working ife. DO NOT use retired) (Specify only highest grade completed) than, Elementary/Secondary (0-12) Hygiene. College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider Page 1 and 2 should be flik ment of Health and Mental ant: If item 27 is marked o ၉ )livel rene ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, ity or, Town, State, Zip Code) 33 MD 21215 timore Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Unit cemetery, crematory or other place) Western 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Himore MD 4 ☐ Donation 5 ☐ Other (Specify) Greene Funeral Bervices ature of Funeral Service Licensee 22. Name and Address of Facility Kandallstown, MD 21133 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

2 down Immediate Cause (Final Physician/ Storge disease or condition resulting in death) aleverse Corner smill lima Medical Due to (or as a consequence of): Examiner patre Encephalopath Esquentially list conditions To Be Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) by the attending physician and stached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day 1 Yes 2 9 Unknown page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed Neutro penra 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death? nutrition 24a. Was an Poor autopsy this certificate has perform 2 🗆 No 2 No 1 🔲 Yes Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number dines July PAS-18240 26 2012 M . B. B . S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (MD) - 21215 ,2401 W. Belvedere Sina Hospital of Baltimore Battimore EDEM 32. Registrar's Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 350A 2017 FRANCES Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 24 Hrs 8. Date of Birth Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days Min. (Month, Day, Year) 05/18/1923 Country) Ohio Months Hours 1 □ M 2 🖔 F Director 294-14-3725 89 Usual Residence of Decede 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 □ No MD Howard Columbia 10e Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral items 23a 21044 **USA** 6334 Cedar Lane #173B death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 5 2 1 Never Married 2 Married altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Completed 3 😾 Widowed 4 🗌 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Did Not Work other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ည Viola Willis George Willis and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 16 Bay Pointe Drive, Ormond Beach, FL 32174 John L. Capelle / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 7/30/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death SEPSIS Physician/ disease or condition Medical resulting in death) Examiner PNEUMO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a
24 hours after cleath.
 Funeral Director: After this certificate has been signed by the attending physicia
is funeral in by the funeral director, page 2 should be detached for use as the burneretely filled in by the funeral director, page 2 should be detached for use as the burneretely filled. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes a No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2VNo မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD UPTA 9650 SANTIAGO Rd 21045

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Patrick Month 1307 07 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical Center Baltimore, MD of University Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 48 yrs. 214-90-9984 1XXM 2 □ F Director 17, 1964 Maryland Jan. Usual Residence of Deced 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a XX Yes 2 □ No Maryland Baltimore City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21230 United States 2828 Maudlin Ave. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2XXMarried ģ 1 Yes 24 If Yes, Give Year or Dates. Maryland 21215-0036 er than "natural", or, the Medical Exam 1 Yes 2 No Specify Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. College (1-4 or 5+) N/A Elementary/Secondary (0-12) 7th Fork Lift Operator R E Michaels Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude M. Reynolds William Thomas Craig other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8448 Maryland Road, Pasadena, Maryland 21122 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trains Patrick T. Craig, Jr./Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery, crematory or other place)
Loudon Park Cemetery
July 27,2012 XXX Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of FacilitAMBROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 tatu Darwar Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Esophaseal to (or as a consequence varices disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Natural 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) P25712 22/2012 MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD

DHMH 17 Rev 06-2011

State Registrar

Isena

31. Date filed (Month, Day,

St.

22 S. Greene

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 10:15 P <sup>M</sup> Call John Lexow Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral Hours (Month, Day, Year) Director 216-16-0570 1 **X** M 2 □ F Oct 9, 1922 89 New York Usual Residence of Decede ed other than "natural", or itama 23a or 28a-f show event, the Medical Examinar must be natified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If itam 27 is merked other than "natural", or Itama 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d Inside City Limits **Funeral Director** 1 ☐ Yes 2 X No Brookeville Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States 20833 21425 Georgia Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates. 1942–44 Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Financial Stock Broker 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Lexow Donald Call 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brookeville, MD 20833 21425 Georgia Ave. Call / Wife J. Frances Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If its any injury or ot 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 7/30/12 Woodbine, Maryland 21. Signature of Funeral Service Licenstee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Artery Coronary disease or condition Medical resulting in death) Due to (or as a consequence of) Éxaminer Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events buriel-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 ed by the attending physical detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sate has been significated be page 2 should be Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' Yes 2 No 1 ☐ Yes 2 ☐ No To the Hoapital or Attending Physician: I within 24 hours after death.
To the Funeral Director: After this certifics completely filled in by the funeral director. **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🖾 Other (Specify) HOSPICE 1 ☐ Yes 2 🔀 No 욛 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 7.26.12 R143201

19x1

State Registrar Debrah Miller

31. Date filed (Month, Day, Year) 2

Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Rd

32. Registrar' Signatura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 04:30 pM Mary Catherine Cordwell July 2012 :6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital Berlin If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours Min. **Director** 219 16 7926 1 M 2 X F 87 Aug. 27, 1924 MD Usual Residence of Decede or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State irector 1 Yes 2 X No MD Harford Bel Air  $\bar{\Box}$ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 21014 300 Ringfactory Rd U.S.A items ? death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. er than "natural", or iter the Medical Examiner Armed Forces?
1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home n and Mental Hygien 7 is marked other th 12 yrs Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cecilia Cavey injury or other traumatic Arthur Custer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 558 Ocean Parkway Ocean Pines, MD 21811 William Cordwell (son) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/2012 Baltimore, MD Gardens of Faith 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Rd. Bel Air, MD 21014 Rarty. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DONONT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \) Yes \( 2 \sum \) No 24a. Was an autopsy performe this certificate has completely filled in by the funeral director, page 2 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury ¥ Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 29b. Signatu re and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Third A MASS Healthway Dr Belin MD

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

7/26/26/2

(lordwell

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 35 AM ENCLYNNE **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson

Vear If Under 24 Hrs. | Min. **Baltimore** Edenwald Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Oct. 15,1914 If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days 1 □ M 2 🖔 F Yrs. Oct. 97 Canada Director 217-09-1376 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f shov dicyl Examiner must be notiffed at 1 ☐ Yes 2X No Funeral Director Baltimore Towson Maryland 10g. Citizen of What Country? 10e. Street and Number U.S.A. 800 Southerly Road Apt. 310 21286 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates: Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steam Ship Agent 12 <u>Bookkeeper</u> 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aermit. Pages 1 and 2 should be be begartment of Health and Mr Important: If Item 27 in any Injury or connec. Bland Fmilv Harman မှ <u>Henry</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Parkville, Maryland 21234 Date 20c. Location - City or Town, State Flovd Bland Brother 1802 Trenleigh Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State Hilltop Service Corp. 7-31-2012 Towson Maryland 4 □ Donation 5 □ Other (Specify) of Funcial Fervice Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signatur 21204 Towson, Maryland 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final EARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ARTERIOS CLEROTIC CARDIDVASCULAR TEMES requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ■ No 5 Other (specify) P.O. ed by the a 9 Unknown signed b be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 VALVE REGURGITATION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed SINUS SYNDROME. STATUS 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 □ Yes 2 KNo page VASCULAR DEMONTA -MILL 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident within 24 hours after death.

To the Funeral Director: Afte completely filled in North 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0022633 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 WEST ROAD. SUITE 201 SECADA-L TOWEN MD OVIO, MA

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32 JUL 3 1 2012

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar		epartment of Health and Certificate of Death	Mental Hygier	7111/ /11/
Physician/ Medical	1. Decedent's Name (First, Middle, Last)  Stacy E. Childs	2. Date of Death Month			
Examiner	4a. Facility Name (if not institution, give street Union Memorial	et and number)	4b. City, Town, or Location of Death Baltimore	n ,	4c. County of Death N/A
Funeral Director	5. Social Security Number 2 1 9 - 8 2 - 4 6 3 2 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs Months Days Hours Min. rs.	8. Date of Birth (Month, Day, Year 05/15/1!	
ryland I-f show ied at	10a. State 10b. County	10c. City, Town			10d. Inside City Limits 1√2 Yes 2 □ No
leath with the Maryland frems 23a or 28a-f sho er must be notified at Fremeral Director	MD N/A  10e. Street and Number		Baltimore 10f. Zip Code	10g.	Citizen of What Country?
eath with	1645 N. Calhoun  11. Marital Status 12.	Was Decedent Ever in U.S.	21217  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	U.S.A.  14. Race - American Indian,
nrs after dural", or it	1 🙀 Never Married 2 ☐ Married 1 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ No Specify:	o Rican, etc.)	Black, White, etc.  Specify: Black
21215-003 ulthin 72 hours at liene. Tr than "natural" the Medical Ext	15. Decedent's Educa (Specify only highest grade of	Completed) College (1-4 or 5+)	Decedent's Usual Occupation Give kind of work done during most of wor ife, DO NOT use retired)	rking 16b	. Kind of Business/Industry
d 21; led within Hygiene other the ent, the	Elementary/Secondary (0-12) 12th Grade  17. Father's Name (First, Middle, Last)	S	ecurity Officer	me (First, Middle, Maide	Rite Aid
/lanc d be file Mental P arked o ttic eve	Anthony Childs			Linell C:	·
Mary Id 2 should saith and I n 27 is mi er traums	19a. Informant's Name/Relationship (Type, Taavon Gilliam(s		Mailing Address (Street and Number or Ru 25 Axehead Ct.,		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In mortant, if tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rer 4 ☐ conation 5 ☐ Other (Specify)	cometen	Disposition (Name of crematory or other place) te Crematory 1-3	I .	Location - City or Town, State
Balti permit. Departi Importa any inji	21. Sgnature Funeral Se vice Licenses	Down	70sephodus Brown 2140 N. Fulton	Jr. FUne:	ral Home PA
	23a. Part 1. Enter the disease, or complical spock, or heart failure. List only one c	tions that caused the death. Do no ause on each line.			Approximate Interval Between Onset and Death
Physician/ Medical	Immediate Cause (Final disease or condition resulting in death)	Pue to (or as a consequence of	):		Offset and Death
Examiner	Sequentially list conditions, if any, leading to immediate	ACUTE RESP	RATORY DISTRES	SYNDR	OME
ecuted and al-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cultinated in death) Last	Due to (or as a consequence of	1.		
50 te be executed sysician and ne burial-transit	d.	Due to (or as a consequence of	•		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  When Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.  Medical Certificate: To Be Completed by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
IS, P.O uires that the signed by all be deta	Part II. Other significant conditions contri	buting to death but not resulting in	the underlying cause given in Part I.		to use contribute to the cause of death?
Division of Vital Records, P.O. all or Attending Physician: The law requires that the s's after death.  In Director, After this certificate has been signed by the din by the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted or the funeral director.				24a. Was an autopsy performed'	24b. Were autopsy findings available prior to completion of cause of death? No! 1 □ Yes 2 □ No
Vital I ysician: 1 iis certifica director, 1 To Be C	25. Was case referred to medical examiner?  1  Yes 2 No	pital:	26. Place of Death (Che		
n of Vi's ling Physic After this co funeral dire	27. Manner of Death  1 Natural 5 □ Pending	1, Inpatient 2 ☐ ER/Out 28a. Date of injury (Month, Day, Year) 28b. Ti	patient 3 \(\) DOA \(\) 4 \(\) Nursing \(\) me of \(\) 28c. Injury at \(\) work?	tome 5 Residence 28d. Describe how in	
ivision of or Attending P after death. Director: After t in by the funer: Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fan building, etc. <i>(Specify)</i>	M 1 ☐ Yes 2 ☐ No m, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Division of V To the Hospital or Attending Phys within 24 hours after death to the Funeral Director. After this completely filled in by the funeral di Medical Certificate: To	(Check 2 Medical Examiner:	On the basis of examination and/or	eath occurred at the time, date and place, investigation, in my opinion, death occurred ledge, death occurred at the time, date and	at the time, date and pla	ace, and due to the cause(s) and manner stated
To the within: To the comple	29b. Signature and title of certifier	MA	29c. License number AT2438946		Date signed (Month, Day, Year)
3	30. Name and address of person who comp	pleted cause of death (Item 23a) (T		IY RAI TIM	TORE MA 21218
State	31. Date filed (Month, Day, Year)	37 Registrar's Signature	Land	VIIDICIII	TOTAL ALATO
Registrar  DHMH 17 Rev 06-2011	302	Menn B. A	pare		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MA CY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SAMARITAN N/A BATIMORE HOSPITA 8. Date of Birth (Month, Day, Year) Aug. 26,1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 217-12-6647-A 87 Director 1 □ M 2X F Maryland Usual Residence of Decedent 28a-f show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 21214 2224 Westfield Ave. U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Donald Skinner Augusta Shepherd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2224 Westfield Ave. Baltimore, Maryland 21214 Carmelo F. Culotta / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Gds. of Faith Cem. 7/30/2012 Overlea, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1050 York Road Towson, Md. 21204 Earl L. Canapp Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ LLMONARY EDGMA-HOURS disease or condition Medical resulting in death) Due to (or as a consequence of Examiner HOURS Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) DAUS. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afrecheath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral inversid rector, page 2 should be detached for use as the burnal-transit completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit PNEWYONIA that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown FIBRILLATION WITH Were autopsy findings available 24a. Was an autopsy performed? Yes 2 XN prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural work? 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and title of certifie 29b. Signat MD les oo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21239 5601 LOCK RAVON TISHEN State Registrar's Sign 3 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 28, Day 2012 Year Physician/ Evelyn S. Coyle 2:05 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Broadmead Cockeysville Baltimore Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye Months Hours Country) Maryland 1 □ M 2 🖵 F 213-26-1248 Director 101 Nov Usual Residence of Decedent shov 10c. City, Town or Location : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits Director MD Baltimore Cockeysville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13801 York Road 21030 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. 11 Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmission. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Н. Sheats Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan C. Davidov-daughter 4100 N. Charles St., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XX Cremation 3 Removal from State Hilltop Serv Corp 7/30/12 Towson, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. G. Dau 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE nse 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 DNO Other: 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify, 27. Manner Death 28a. Date of injury (Month, Day, Year) ie: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Unatural 5 Pending Certifica 2 🗌 No 1 🗌 Yes Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

JUL 3 1 2012

2103

Item 23a) (Type Print)

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:30 P M Elizabeth Kujbus Domby 2012 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Brighton Gardens If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Age (In yrs. last birthday) 1 □ M 2 🕱 F (Month, Day, Yea, av 15 Days Hours West Virginia 78 1934 Director 233-54-6735 May Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1X Yes 2 □ No Beckley WV Raleigh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25801 USA 120 Patteson Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. White Specify "natural", 3 🛮 Widowed 4 🗆 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Merital Hygiene. Important: If item 27 is marked other than "natur. any injury or other traumatic event, the Medical sonce. 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher's Aide Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Margaret Emry Mike Kujbus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8600 Sassafras Ct., Columbia, MD Stefan Louis Domby Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sunset Memorial 1 X Buriol 2 Cremation 3 Removal from State 7-30-2012 Beckley, WV 4 Donation 5 Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service Silv ature of Funeral Service Lines 5517 Vine Street, Alexandria, VA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTHS Immediate Cause (Final Pfugucian Esophageal Dysmotility disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ģ Month Day Year Pregnant at time of death been signed by the should be detached g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dysphagia 24b. Were autopsy findings available prior to completion of cause of death? Alzheimer's Disease 24a. Was an has autopsy 1 ☐ Yes 2 🗓 No 1 🗌 Yes 2 🕱 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA ျှ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death.

I Director: After the in by the funeral Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 🗓 Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

24 hours a Funeral Leted filled Hospital within 24

To the Fe

> State Registrar

3 29b. Signature and title of certifier

Harry Li, MD

8600 Snowden River Parkway, #301, Columbia, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MP

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

July 26, 2012

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D56531

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 2 per doc 9929 7-31-12 yt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ <sup>Year</sup> 2012 8:20 pM James Francis Dietsch Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Country) Maryland (Month, Day, Year) 04/23/1929 Days Hours Director 1 1 M 2 | F 217-24-3817 83 Vrs Usual Residence of Deceden and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It has 23a or 28a-f show tem 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State **Funeral Director** 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 3407 Liberty Parkway 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify. 3 NVidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Steel Worker Steel Mill 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Dietsch Marie Zoch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7342 Manchester Road, Baltimore, MD 21222 James C. Dietsch / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5 permit. Page Department of importent: if any injury or once. 4 Donation 5 Other (Specify) Chesapeake Crematory 7/24/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Jude Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ RENAL Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to humocrate cause. Enter Underlying Cause (Disease or injury Examine Je cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnance in the past 12 months? Pregnant at time of death Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part-23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 2 No 3 Probably 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an RONARY ARTERY DISEASE autopsy To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag HYPERTENSION 1 ☐ Yes 2 ☐ No **Division of Vital** or Attending Physicien: 26. Place of Death (Check only one) æ examine? Other: 4 Nursing Home 5 Residence 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 6 Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 15/2012 unknow.M Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 34071. Sept y Pkun ace of Injury - At home, farm, street, factory, office 28e. determined building, etc. (Spec Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this confidence. Records, P.O. Box 68760 Division of Vital

State

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation

determined

6 Could not be

130 H. Kelly

Accident

3 ☐ Suicide 4 ☐ Homicide

only one) 29b. Signature and title of certifie

29a. Certifier

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ 2012 12:42pM July JOSEPHINE DAVIS Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5900 PARK HEIGHTS AVE., APT 416 N/A BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Hours Months Min (Month, Day, Year) 1 - M 2 XX **Director** 218-48-0768 FEB. 13 1951 SOUTH CAROLINA 61 Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ the Maryland Director notified 1 X Yes 2 ☐ No MARYLAND N/A BALTIMORE 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 5 must be 23a with 5900 PARK HEIGHTS AVE., APT 416 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Medical Examiner Armed Forces? 1 Never Married 2 Married o. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the NURSES ASSISTANT HEALTH CARE 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H
fitem 27 is marked ot
r other traumatic ever 2 JOSEPH DAVIS MARY LOU MACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2529 Quantico Ave., Baltimore, Md., 21215 Tiny R. Davis/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) 08-02-12 KING MEMORIAL PARK BALTIMORE, MARYLAND 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE, BALTIMORE, MD., 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION Physician/ MYOCARDIAL disease or condition Medical resulting in death) Due to (or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of) attending physician Physician/Medical Box 687 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death ed by the ar P.O. signed by Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by UTERINE Division of Vital Records, CHNCER 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No GASTRIC CANCER 24a. Was an autopsy performed Yes 2 HYPERTENSION 25. Was case referred to medica Hospital or Attending Physician: funeral director. Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 030377 130, 2012 31. Date filed (Month, Day, Year, 32. Registrar's Signature State JUL 3 1 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 5:55 A M Lois В. Deming Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Gilchrist Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Oct 12. Months Min Days Hours California Yrs Director <u>566-22-2953</u> 88 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Columbia Howard should be filed within remediate Mental Hygiene.
27 is marked other than "natural", or items 23a or so is marked other than "hatural", or items 23a or marked other the Medical Examiner must be remarked. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 7565 Weatherworn Way #B 21046 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Guv W. Buckmaster Cassandra Hazzard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Columbia, MD 21045 Jon Deming / Son 6404 Loring Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 7/31/12 Woodbine, Maryland 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) SEIZURES MEDICAL CHAMINER MED Examiner Sequentially list conditions, it any, leading to immediate cause. Enterprise (Pierranderlying Examine sician and burial-transit law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical CE P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No for 5 Other (specify) Month Pregnant at time of death Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Records, 1 Yes 2 No 3 Probably 4 Unknown been signatured b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 Hospital or Attending Physician: The certificate INA us. E 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 1 ☐ Yes 2 ☐ No 은 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred walking with carregives. had A full And what appeared Doe A 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 2 No injury 1 
Natural 5 Pending July 19, 2012 2 Accident Investigation 102K2022 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) on Sidewalk Outside of home 28f. Location (Street and Number or Rural Route Name). determined City or Town, State) 7565 Weather we In Way, Apt. B Cour Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. MO 21046 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 27, 2012 25205 30. Name and address of person who impleted cause of deat n (Item 23a) (Type, Print) N. Charles St. Balto Md 21204 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 4:44 AM Robert Wallace Donaldson, Jr. 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALTIMORE HOSPITAL B AGNES If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours March 18,1923 062-18-7719 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 1 ☐ Yes 2 X No Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 717 Maiden Choice Lane ST403 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Westinghouse h and Mental Hygies 7 is marked other the 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Robert Wallace Donaldson, Sr. ည Frances Sophia Gumtow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health Department of Health Important: If item 27 any injury or other tr 258 Nathan Way; Millersville, 27 David Donaldson MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 7/27/2012 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Similar Licensee Moi 23 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MYOCAKDIA Immediate Cause (Final NON 2 **Physician** WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): FAILURE Examiner Weeke CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed Due to (or as a consequence of) physician a the burial-1 68760 Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 1 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s certificate 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending n 24 hours and he Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 🛈 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P25490 W- A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimure, MD AMAR, 900 31. Date filed (Month, Day, 32. Registrar's Signature State 3 1 2012 Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Fonia Louise Dame 05:55 A M Ju1y Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Co. Morningside House of Friendship Hanover 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 315-34-1749 Director 1 □ M 2X □ E 91 01/23/1921 ID r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hyglene. al Hyglene. 4 other than "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severn 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21144 1393 Teaberry Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify White 3 KWidowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registared Nurse Healthcare 4 Ith and Mental Hygie 27 is marked other treumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ pe Daisy Courtney permit. Page 1 and 2 should be Department of Health and Men' Important: If item 27 is marke any Injury or other treumatic Noah Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1393 Teaberry Lane Severn, MD 21144 Dennis Dame 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 7/29/2012 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 21. Signatu y of Funeral Section 22. Name and Address of Facility Singleton Funeral & Cremation MD 21061 Services PA; 2nd Ave SW; Glen Burnie, 23a. Part 1. Enter the disease, of samplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Ofset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as consumence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physiclan/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death ate has been signed by the a page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tes Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 2 1 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifia

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State Registrar 31. Date filed (Month, Day,

death (Item 23a) Mype, Print)

32. Registrar's Signatur

who completed cause of

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death  $J_{u1y}^{Month}$ 2012 Physician/ Marjorie Ann Dreyfus 4:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 27,1932 9. Birthplace (State or Foreign Country) Indiana 5. Social Security Number Age (In vrs. last birthday) **Funeral** Director 80 317-30-0450 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 X No Rockville MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a United States 6121 Montrose Rd. 20852 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Deceded
Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. University and Elementary/Seconday (0-12) College (1-4 or 5+) Private Practice Psychiatric Social Worker 5+ Be 18. Mother's Name (First, Middle, Malden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic evenore. 17. Father's Name (First, Middle, Last) ဂ္ Shaw Tapscott Helen Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 Rutledge Ave., Charlottsville, VA Emily Dreyfus / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Chesapeake Crematory 07/30/2012 4 Donation 5 Other (Specify) Beltsville, MD <sup>22</sup> Name and Address of Facility Rapp Funeral and Cremation Serv<u>i</u>ces Mc0382 Silver Spring, MD 20910 Gist Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARPIAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death No. the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performer Yes 2 has After this certificate within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5  $\square$  Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventigation in muscial and dath arms of the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 001808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIZI MONTROSF M.D.

State Registrar 31. Date filed (Month, L

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32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July 2012 Physician/ 2:26 P M Drucker Evelyn Weiss Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Spring House Assisted Living If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Date of Day, (Month, Day, 1 V 27 9. Birthplace (State or Foreign **Funeral** Months Hours 1 M 2 F 328-14-2515 92 July Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland iral", or items 23a or 28a-f shor Examiner must be notified at Director 1 Yes 2xx No Montgomery Bethesda MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 4925 Battery Lane United States 20814 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: White If Yes Give Specify: 3 Widowed 4 □ Divorced "natural" Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ital Hygiene. ed other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Elementary Education Librarian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) alth and Mental H 27 is marked of ir traumatic even မ Page 1 and 2 should be in ment of Health and Menta Weiss Lillian Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alison Drucker / Daughter 7020 Wilson Lane, Bethesda, MD Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory: 07/30/2012 Rapp Funeral and Cremation Services M00382 20910 933 Gist Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LIVER FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) Yes 2 X No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA, OSTEOPAROSIS, 2√No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSIVE HEART DISEASE autopsy performed? has certificate 1 Yes 2 No Yes ♥ No 25. Was case referred to medica 26. Place of Death (Check only one) Be director assisied examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) LIVING 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ည After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 🛛 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 I Medical Examiner: On the best of examination and/or inventionities in the property of the pr Medical 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title certifie 29c. License number 7/2012

101 State

Registrar DHMH 17 Rev 7/2009 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN J. MILLER, M.D.

31. Date filed (Month, Day, Year)

D35579

8218 WISCONSIN AVE. #305, BETHESDA, MD

			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
			State of Maryland / Department of Health and Mental Hygiene  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2012 24139
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  3. Time of Death
-	Medic Examin	al	Richard Albert Day  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
(بر	Examin		SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE
	Funeral Director		5. Social Security Number 212-42-9616   Usual Residence of Decedent    6. Sex 7. Age (In yrs. last birthday)   67
	Maryland :8a-f shov tiffed at	To Be Completed by Funeral Director	10a. State     10b. County     10c. City, Town or Location     10d. Inside City Limits       Maryland     Baltimore     Timonium     1 □ Yes 2 ★ No
	vith the l		10e. Street and Number 12330 Rosslare Ridge Road Unit 103 21093 10g. Citizen of What Country?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		12. Marital Status  1 Never Married 2 XMarried 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036			15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+) 4  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Owner  Self Employed
Maryland 2	d be filed w fental Hygi irked other tic event, t		17. Father's Name (First, Middle, Last)  Albert Nicholas Day  18. Mother's Name (First, Middle, Maiden Surname)  Bernadette Kober
Mary	should hand N 7 is ma trauma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  21093  19c. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Day / Wife
	1 and 2 of Healt item 2 other		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Baltimore,	t. Page tment c tant: If jury or		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Dulaney Valley Mem. 8/3/2012  Timonium, Maryland
Bal	permit Depar Impor any in		21. Signature of Funeral Septice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204
	Physician Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death Onset and Death
۲	Examiner		CORONARY ARTERY DISEASE
	ted Insit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury
90	te be executed lysician and he burial-transi		that initiated events resulting in death) Last    Due to (or as a consequence of):  d.
s, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live Birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify)   Month Day Year
	requires that the des been signed by the a should be detached 's	To Be Completed by	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  ACUTE RESPIRATORY FAILURE  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4 X Unknown
Records,	The law req ate has bee page 2 sho		24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 🌠 No 1 □ Yes 2 □ No
	sician; The certificate irector, paç		25. Was case referred to medical examiner? 1   Yes 2   No
of Vital	ding Phys h. After this funeral di		27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred work?
Division	or Attendi after death. Director: A I in by the fu		2 Accident 3 Suicide determined Investigation 4 Homicide Suicide determined Several Route Number, Suicide Suicide determined Several Route Number, Several
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Af completely filled in by the fu		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)  3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To th within To th	8	29b. Signature and title of continue 29c. License number 29d. Date signed (Month, Day, Year) Tuly 28, Zo1Z
0			30. Name and afforess of person who completed cause of death (Item 23a) (Type, Print)  KHOSROW TABASSI, M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204
	Stat		31. Date filed (Month, Day, Year)  32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Joan L. Eifert July Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death 9101 Covered Bridge Road Baltimore Baltimore Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Mar. 28, Year 931 1 M 2 J Months Days Hours Min 215-28-2886 **Director** 81 Maryland Usual Residence of Decedent 28a-f show 10a, State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore MD 1 🗌 Yes 2 💢 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral Covered Bridge Road 21234 9101 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give white Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Good Samaritan Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Hospital 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Henry Bischoff Lillian Ridgley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9101 Covered Bridge Road-Baltimore, MD 21234 1 and 2 s if Health i Carl Eifert-spouse injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gardens of Faith Aug. 2, 2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 21. Signature of Funeral Service Licenses LM Fadd condus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Metabolic Immediate Cause (Final Onset and Death Physician/ ceonal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery Box Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown detached P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death?
1 Yes 2 No perform this certificate Division of Vital To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury death Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after of To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🗷 🔾 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 65032 who completed cause of death (Item 23a) (Type, Print) YORK 1447 SUTTE LUTHERVILLE MD 21093 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 1 2012

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Month Physician/ 26 8:10 Marion Forte Ju1v Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 246-82-6142 **Director** 1 🗌 M 2 🔀 F 85 Yrs. Oct. 23, 1926 North Carolina Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director NC Polkton 1 Yes 2 No Anson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? o ms 23a or must be r Funeral 28135 USA 5719 White Store Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian "natural", or item edical Examiner n 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than aumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Teacher's Aide School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Funderburk Joel Leak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important; If item 27 707 Farmcrest Drive, Charlotte, NC Barbara Leak Hill - Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Westview Memorial Park 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 7-31-2012 4 ☐ Donation 5 ☐ Other (Specify) Wadesboro, NC e of Funeral Service Ligensee 21. Signaty 22. Name and Address of Facility Metropolitan Funeral Service any in 5517 Vine Street, Alexandria, VA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Overlon disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending philon for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Respondery Failure 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should Overload disorder 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital 1 ☐ Yes 2 XNo မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury\_at Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

7503 Surratts Road,

OW

CRNP

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Seraphine Leunkam,

31. Date filed (Month,

14

Clinton, MD

			Please	Type or Print in t						
			For	State of Marylan			Mental Hygien	е		
1 - State Registrar Certificate of Death Reg. No. 2012							21113			
	Physicia Medic		1. Desedent's Name (First, Middle Lass Altred Nau		mings		2 Date of Death July 27	ay 2012	3. Time of Death 5.30 P M	
	Examin		4a. Facility Name of not institution, give	btreet and number)	n   / 1	Town, or Location of Death	0 4	Balti	more	
	Funeral Director		5. Social Security Number 6. Se		st birthday) IT Und Months Yrs.	er 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	Cou	nplace (State or Foreign ntry)	
	fand fshow dat	tor	Usual Residence of Decedent  10a. State  10b. County		, Town or Location	11	16/01/1	551	10d. Inside City Limits	
	the Mary or 28a-1 e notifie	Director	10e. Street and Number	more (	6+075 Vi	ip Code	10g. C	Citizen of What Cou	1 Yes 2 146	
	ath with	Funeral	1020 Craftsw 11. Marital Status	00d Kod	i. 13. Was Dece	21228 edent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ican Indian.	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tier Z7 is marked other than "natural", or items 23a or 28a-f show min injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 May Yes 2 No If Yes, Give Year or Dates.	If Yes, spe	ecify Cuban, Mexican, Puerto	Rican, etc.)	Black, White		
21215-0036	72 hours n "natur ledical B	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Decedent's Us (Give kind of w life IPD NOT us	ork done during most of work	sing 16b	Kind of Business/	States	
	ed within Hygiene. other thai	Be Cor	Elementary/Secondary (0-12)	College (1-4 or 5+)	Na:	Clerk	Pina Middle Maid	ostal (	Service	
Maryland	should be file and Mental H is marked of aumatic ever	To B	17. Faher's name (First, Middle, Last) Kutus Flem	ring	,	Bet	ne First, Middle-Maidel Ty Jon	es		
	and 2 shoul Health and tem 27 is m		1A. Informant's Name/Pelationship (Ty Ashley Flemm	I TOO I I ITOI	19b. Mailing Address	s (Stree and Number or Rui	Baltimer, City of	or Town, State, Zip	21229	
nore,	Page 1 and nent of Heal ant: If item 3 ury or other		20a. Method of the position 1 ★ Burial 2 □ Cremation 3 □	Removal from State 20b. P	lace of Disposition (Name terry, crematory	ame of other place)  West 8		Location - City or	Town, State W:115, MD	
Baltimore,	permit. Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licenses)		News	and Apples @ Far (B) (C)	ene fuger	al Sen	1: ces	
	40760		23a. Part 1. Ento the disease, or compshock, or heart failure. List only of	Dilications that caused the death	5.50 not enter the mo	Bauto. Note de of dying, such as cardiac	or respiratory arrest,	e (212	Approximate Interval Between	
1	Medical	1	Immediate Cause (Final disease or condition resulting in death)	a. Hepatoct	e//ular	Cancer			Onset and Death	
	Examiner	er	Sequentially list conditions,	b. Due to jor as a consequ					,	
	cuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
0	e be executed ysician and ne burial-transit	g	resulting in death) Last	Due to (or as a consequent d						
Box 6876	requires that the death certificate I been signed by the attending phys should be detached for use as the	Physician/Medio	23b. Was decedent pregnant	23c. If yes, outcome of pregna		c pregnancy		23d. Date of del	ivery	
. Bo	he death y the atte ached for	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of c				Month	Day Year	
Division of Vital Records, P.O.	ires that t signed b id be deta	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Part I.			the cause of death?	
cord	law requ nas been e 2 shou	Completed	24a. Was an autopsy						24b. Were autopsy findings available prior to completion of cause of death?	
Re	The cate	ပ်					performed?		2 🗆 No	
ta	cian: ertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death (Che				
⋛	Physic this c	은	1 Yes 2 No  27. Manner of Death	1 L Inpatient 2 L	ER/Outpatient 3   28b. Time of	DOA 4 Nursing F	lome 5 Residence		ify)	
o uo	I or Attending Physician: The law after death.  Director: After this certificate has d in by the funeral director, page 2	Certificate:	Natural 5 Pending 2 Accident Investigation		injury M	28c. Injury at work? 1  Yes 2  No	28d. Describe how inju			
Divisi	al or Att s after d al Direct ed in by		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Exami	sician: To the best of my know iner: On the basis of examination se Practitioner: To the best of r	n and/or investigation,	in my opinion, death occurred	at the time, date and pla	ce, and due to the o	cause(s) and manner stated.	
	vithir von Comp	4	20h Signature and title of certifier	he Col	2	9c. License number		ate signed (Month	, Day, Year)	
	58		30. Name and address of person who of Sulf in more, The			Charen J.	Mc Cornet	KMP		
	Sta		31. Date filed (Month, Day, Year)  1111 3 1 2012	d. 2/239 32. Registrar's Signal	ture de la companya d					
	Reaistr	: l'	1 1111 O A CUIC (4	EMPT - 17						

Altred wayne Flemmings

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 0 7 Physician/ 7:20 PM ANLEAH TRANCIS Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthdav) 8. Date of Birth Birthplace (State or Foreign Country) 50-07-6391 Director 1 № M 2 🗆 F 08/15 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a State within 72 hours after death with the Maryland 10b Count 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral FAIR VAKS USA 21214 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 1 Never Married 2 Married 2 1 Yes 2 No Specify. 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. US POSTAL SERVICE Elementary/Secondary (0-12) College (1-4 or 5+) Mail CARRIER should be filed very and Mental Hyg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY NILLIAM E. FRANCIS 19a. Informant's Name/Relationship (Type, Print) DAUGHTER TUCKER Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Importent: If ite eny Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md GARRISON FOREST 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNGRACS CUS 21. Signature of Funeral Service Ligensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Deuention

Due to (or as a consequence of) Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami as the burial-transit eral Director. After this certificate has been signed by the ettending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death 5 Other (specify) Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 M Other (Specify) 1 Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5  $\square$  Pending 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral D Medical 29a. Certifie completely only 29b. Sigr D0071287 rson who completed cause of death (Item 23a) (Type, Print) Shaheen 6701 N. 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ICTORIA JUI 2012 M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manor Care Ruxton Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) (Month, Day, Year)
December 21,1916 Months Days Hours Min 218-10-7159 1 □ M 2 X 95 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Carroll Sykesville Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6513 Bonnie Brae Road 21784 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: þ 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 10 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Stabile Marie Trotta ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Shull Daughter 46 Cinnamon Drive, Conowingo, Md. 21918 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 30, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Oak Lawn Cem. 4 ☐ Donation 5 ☐ Sther (Specify) 21. Signature of Fuse al Service Licenses <sup>22</sup>Connerly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UNG DAYS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death), act Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 🗌 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \)

Examiner Box 68760, P.0. Division of Vital Records,

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran cate has been signed by the page 2 should be detached certificate After this certification, property of death. within 24 hours after death To the Funeral Director: Hospital

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Wedfan Event and the notified at once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

State

filled in by the

completely

29a. Certifier

(Check only one)

30. Name and addre

29b. Signature and title of certifier

hand

Registrar

31. Date filed (Month, Day, Year)

32! Registrar's Signature 0

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

July, 28, 2012

PORTH CHARLES STREET, BALTIMORE MD 21204

ompleted cause of death (Itel = 3a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 2414
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		1- For State Certificate of L	Death	R	eg. No.	1.0
Physiciar Medical Examin	1/	1. Decedent's Name (First, Middle,Last) Junious Ernest Fields		2. Date of Dea Month July 22, 20	Dav Year	3. Time of Death 1238 hrs
			. City, Town, or Location of De Baltimore	ath	4c. County of Death N/A	
Funeral Director		249-96-7048 <sub>1×M-2</sub> F 60 <sub>Yrs.</sub>	If Under 1 Year If Under 24  Months Days Hours N	Hrs. 8. Date of Bir Min. 11/18	th(MM/DD/YYYY) 9. Bir / 5.1 Foreig	
Maryland 28a-f show any 1 at once.	ō	Usual Residence of Decedent  10a. State				10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 11 W. 20th StApt. 12R	10f. Zip Code 21218	1	0g. Citizen of What Cour USA	ntry?
fter death wi	by Funeral	1 X Never Married 2 Married Armed Forces? If Yes, 1 Yes 2 No	Decedent of Hispanic Origin? ( , specify Cuban, Mexican, Pue es 2 No specify:		14. Race - Ameri White, etc. Africa Specify: Ame	
5-0036 lled within 72 hours a: Hygiene. The man "natural the Medical Examin	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+)  1 2  College (1-4 or 5+)  La	Usual Occupation (Give kind tof working life, DO NOT use borer	retired)	College	•
215- be filed antal Hyg rked oil	8	17. Father's Name (First, Middle, Last) Eugene Fields	Property of the Control of the Contr	me (First, Middle, M YS YS Benj		
e, MD 21  I and 2 should Health and Ms Health and reframmete		Patricia Jackson/Sister 603 S	ddress (Street and Number of Opwith Dr.	Apt. L,	Balt.,MD	21220
Fife		20a. Method of Disposition  1 ABurial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition crematory or other Mt. Carm	rel Cem. 7	/2 <b>9</b> /12	Balt., MD	·
Baltimo permit. Page Department o Important: injury or oth		21. Signature of Juneral Service Licensee 22. Nan 512	ne and Address of Facility H 6 Belair Rd	ari P. ,Balt.,	Close F.S MD 21206-	vs.PA 5105
Physician /Medical Examiner		Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosc1  Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	Jer	Sequentially list conditions, if any leading to immediate Due to [or as a consequence of]:				
ted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit	Medical	x AMENDED #18, per fh, g929	7-31-12 sm8-3	pt.II,27, -12 sm		
Box 68760, re death certificate be executed the attending physician and red for use as the burial - transi	Physician/M	past 12 months?	death 3 Ectopic preg	gnancy	23d. Date of delivery Month	Day Year
ires that the signed by the leached		Part II. Other significant conditions contributing to death but not resulting in the und Chronic Alcohol Abuse	erlying cause given in Part I.		bacco use contribute to	
Division of Vital Records, P.O. I tal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by the fineral director, page 2 should be deached the statifications of the Commission of the Decommission of	Completed by			24a. Was a autop perfor	sy prior to dom <u>ed?</u> death?	topsy findings available completion of cause of
Vital F ysician: his certifi director,	e D	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Che		Residence 6 🗸 Other	Cana
n of Vi	2	727. Manner of Death  1 X Notice (Month, Day, Year)  1 X Notice (Month, Day, Year)			now injury occurred	. Scene
	Certification:	5 Pending Investigation Suicide Could not be determined  Suicide Homicide  Pending Investigation 28e. Place of Injury - At home, farm, street, 1 (Specify)		28f. Location (S or Town, S	Street and Number or Ru tate)	ral Route Number, City
	. ا ق	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred and manner stated.				
F 2 4 8	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mor	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. E		nore, MD 2122	3	
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BESSIE **FULWOOD** 11:00 AM 201 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death Regional Hospital Laurel dure Prince George's 5. Social Security Number If Under Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 250-72-7537 SOUTHCAROLINA Director 1 DM 2 KF 10/8/1942 69 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 5000 NANNIE HELEN BURROUGHS UNITED STATES 20019 ural", or items? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 er than "natural", or, the Medical Exam 1 ☐ Yes 2x No Specify: Specify: BLACK Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) CHEF PRIVATE other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I မှ REBECCA DOMINICK PINK WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a RD EDGEFIELD, SC 29824 CLEOPHUS WILLIAMS/BROTHER 15 BROOK CREEK 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important; If it any injury or conce. 1 Burial 2 X Cremation 3 Removal from State BELTSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) SAPEAKE CREM 21. Sign Hay of Funeral Service Lig 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE NE WASHINGTON DC 20002 omplications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part 1. Enter the disease, or Approximate Interval Between shock, or heart failure. List of Immediate Cause (Final Onset and Death Sepsis Physician/ disease or condition resulting in death) Davs Medical Due to ( r as a consequence of): Examiner Diabetes Mellitus II Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension Years that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase at the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Artery Disease 1 Yes 2 No 3 Probably 4 Unknown page 2 should Respirator 24b. Were autopsy findings available prior to completion of cause of death? ailure 24a. Was an has performed? Yes 2 No certificate 1 🗆 Yes 2 🗆 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 Tes 유 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending after death. Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D28998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pritam S. Saini, MD 9101 Cherry Pritam S. Cherry Suite 211 31. Date filed (Month, Day, Year) State

Registrar

			Please AMEND #26 PER	Type or Print in Bla VERBAL G929 7/31	ck Indelible Ink. Ensure 12 Department of Health and	All Copie	s Are Legible	
			For State Registrar	State of Maryland /	Certificate of Death	Mental ny	giene 2011	2 24148
	Dhusisis	/	Decedent's Name (First, Middle, La			2. Date of De	anth	3. Time of Death
	Physicia Medic	al	CLAUSIA	T. Gobur		July	2 20 Year	
	Examin	er	4a. Facility Name (if not institution, giv	h mad Cti	77.0	ruine	4c. County of Dea	A.
	Funeral Director		010 11 1000	7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min  Yrs.			rthplace (State or Foreign ountry)
	Maryland 28a-f ahov affiled et	Director	10a. State 10b. County	10c. City, Tov	whor Location  Himore			10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	death with tha Maryland itema 23a or 28a-f aho ner must be notified et	Funeral Di	10e. Street and Number 4/1/7 Norfolf	< Avenue	10f. Zip Code 21214		10g. Citizen of What C	ountry?
9600	1 and 2 should ba filad within 72 hours aftar death with tha Maryland of Health and Martel Hyglana. Item 27 is merked other then "natural", or itema 23a or 28a-f ahow other traumetic event, the Mudical Evertanar must be notified at	ģ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify:	
21215-0036	within 72 hor glana, er then "nat , the Medio.	Be Completed	15. Decedent's (Specify only highest g	Education 16 rade completed)  College (1-4 or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 4	16b. Kind of Business	Industry Care
	ba filad wi tntel Hygis ked other c event, ti	To Be (	17. Father's Name (First, Middle, Last)	Gaburn	18. Mother's Na	· ()	, Maiden Surname)	Vare
Maryland	2 should the and Me 27 is meritanent		19a. Informant's Name/Relationship (		3b. Mailing Address (Street and Number of Ri 2030 E. Federal 5		er, City or Town, State, Z	ip Code) MD 21213
ore,	0 × ± ×		20a. Method of Disposition 1 Burial 2 Cremation 3	20b. Place	of Disposition (Name of lery, crematory or other place)	Date	20c. Location - City o	
Baltimore	t. Pa rtmar rtent		4 Donation 5 Other (Spec	fy) Ar	butus (emotery 7-1	11-2012	Ba/time	ore MD
Ba	parmi Dape Impo any Ir	2 3	Vausher C.	Rune	8728 Liberty R	Rane	allstown	MU 2-1/33
F	hysician/ Medical Examiner	6	Part 1. Enter the disease, or conshock, or teen failure. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence	GARCIONASCUI	For respiratory and	) 15 <i>CA-5</i> ~	Approximate Interval Between Onset and Death
	axacutad an and rlal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
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. Box 68760	Hospital or Attending Physician: The law raquires that the death cartificete be axacuted the hours after death.  Fur hours after death.  Fur hours after this cartificate has been signed by the attending physician and attaly filled in by the funeral director, page 2 should be deteched for use as the burial-transit	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome of pregnancy 1  Live Birth 2  Fetal dea 4  Pregnant at time of death 9  Unknown			23d. Date of de Month	elivery Day Year
, P.O.	i law raquiras that tha dai has baan signad by the i ge 2 should ba dateched	l by Ph	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.		tobacco use contribute to	o the cause of death?
Division of Vital Records,	law raquli las baan e 2 should	nplete				24a. Was	an 24b. Were at	topsy findings available completion of cause of
Be	Physician: Tha lav r this cartificata has aral diractor, page 2		25. Was case referred to medical			1 🗌 Yes	ormed? death? 2 No 1 ☐ Ye	s 2□No
Vita	ysiciar s cartii diracto	To Be	examiner?	Hospital: 1 Inpatient 2 🛣 ER/0	26. Place of Death (Che		dence 6 Other (Spec	-:6.)
of	ng Phy fter thii inaral		27. Manner of Death  1 Natural 5 Pending		Time of injury at work?		how injury occurred	city)
sion	ttendli daath. ctor: Ai y tha fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not	De 28a Disco of Injury. At home of	M 1 Yes 2 No	006 11 4	0	
Ö <u>X</u>	To tha Hospital or Attending Ph within 24 hours aftar daath. To tha Funeral Director: After thi complataly fillad in by tha funaral		4 Homicide determined	building, etc. (Specify)		City or Tox		
	tha Hospita hin 24 hours tha Funeral hplataly fillad	Medical	(Check 2) Medical Exam	iner: On the basis of examination and	, death occurred at the time, date and place, /or investigation, in my opinion, death occurred owledge, death occurred at the time, date and	at the time date a	and place, and due to the	cause(s) and manner stated.
	To tha within 2 To tha compla		29b. Signature and title of certifier	P. Jons	29c. License number 0 060: (Type, Print) 655 k	526	29d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who	completed dause of death (Item 23a)	(Type, Print)  M.D. 695 K	Tomer	- (CA 2	1035
	Stat Registra		31. Date filed (Month, Day, Year)	32. egistrar's Signature	bare	1110		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 28 Day 2012 12:20 P.M Louise Madeline Glover Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Examiner Rosedale Franklin Square Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex Month, Day, Year) Sept 1921 **Funeral** Months Days 214-14-8013 90 Yrs Balt., Maryland 1 □ M 2 🔀 F Director 10d. Inside City Limits 10c. City, Town or Location 10b. Count death with the Maryland er than "natural", or items 23a or 28e-f sho Parkville Director 1 Yes 2 XNo Baltimore Maryland 100\_Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 21234 of America Funeral 8333 Kendale Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black White, etc. Armed Forces?

1 Yes 2XXNo 1 Never Married 2 Married white þ 1 ☐ Yes 2 ☑ No Specify: Specify: Maryland 21215-0036 Yes, Give 3 

Widowed 4 □ Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education kind of work done during most of working (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other treumastra Be 17. Father's Name (First, Middle, Last) Elizabeth Blumenshein Catherine ည Henry Yungmann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9600 Haven Farm Rd. Unit J Perry Hall, Maryland Mr. Thomas A. Glover/ son 20c. Location - City or Town, State August 1, 20b. Place of Disposition (Name of 20a. Method of Disposition Dulaney Valley 1 Surial 2 Cremation 3 Removal from State Timonium, Maryland Memorial 4 Donation 5 Other (Specify) Gardens 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licens 10 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mont Immediate Cause (Final 51 Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner S e00 rtic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the funeral director. Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 5 Other (specify) g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by hronic 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) a Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>|</u> 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury 27. Manner of Death Certificate: injury (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier us. ted cause of death/(Item 23a) (Type, Print) 30. Name and address of person who co 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :02 P M JULY Ursula Gill Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SAINT JOSEPH MEDICAL CENTER OWSON Year If Under 24 Hrs. Social Security Number If Under Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** . Age (In yrs. last birthday) Hours Min (Month, Day, Year) 220-60-1860 **Director** 1 M 2 X F 79 Dec. 8, 1932 Scotland Usual Residence of Deceder 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗌 Yes 2 🔀 No Maryland Montgomery Silver Spring ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1333 Colesberg Street 20905 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ò 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) 5+ Years Elementary/Secondary (0-12) Artist Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Iliff John Kenneth Giles Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1333 Colesberg Street Silver Spring, Maryland 20905 Amarjit Singh Gill (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory, Inc. 7-31-12 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home,
6500 York Road Baltimore, Mary elran 21212 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MINUTES disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner YOCARDIAL INFARCTION MINUTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami ARDIOVASCULAR attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death Year signed by the detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 24a. Was an page 2 1 Yes 2 No 25. Was case referred to medica completely filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signa 29d. Date signed (Month. Day. Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON MARYLAND 21204 05L 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ July 27, 2012 Goff 3:46 AM Erwin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🛛 M 2 🗌 Months Days Hours Min. 88 1923 Florida 262-24-5805 Sep. **Director** Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director r 28a-f sl notified 1 Yes 2 X No Baltimore Lutherville Timonium 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? be r items 23a c Funeral 2213 Pine Valley Drive 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?1 X Yes 2 ☐ No 11, Marital Status 14. Race - American Indian, "natural", or itel Black White etc. Completed by 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Master Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ျ Lila Featherly Francis Goff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Carole G. Coleman - Daughter 2213 Pine Valley Drive, Timonium, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Buria 2 ☐ Cremation 3 ☐ Removal from State 17-31-12 Bunset Memorial Park Chester, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service Signature of Funeral Service Licencee, rich 5517 Vine Street, Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
hours shock, or heart failure. List only one cause on each line Immediate Cause (Final Myocardial Infarction Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Coronary Artery Disease years Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha performed 2 🗌 No 1 🗌 Yes 1 ☐ Yes 2 [ Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation Director: / Sulcide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours at To the Funeral Dicompleted filled in

 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Bohnes 6535 Charles STreet

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Alexander GRAY Medical Examiner 4c. County of Death GILCHRIST Baltimore TOWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) Director 1 **X**-M 2 □ F 68 TRINIdad + Tobago Usual Residence of Decedent permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is merked other then "neturel", or iteme 23e or 28e-f show any injury or other treumetic event, the Modical Examinating at all any injury or other treumetic event, the Modical Examinating at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Md Baltimore 1XX)Yes 2 \( \subseteq No 10g. Citizen of What Country? Funeral SPRINGFIELD AVENUE 21212 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ፩ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) HOWARD COUNTY ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) harles leonetta Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1522 GREENdale Rd. Baltimore, Md. 21218 RICE (DAVEHTER) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State On-SITE CREMATION Baltimore, Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHT GREENE FUNERAL SCUS 21. Signature of Euperal Service Licenses 4905 York Road. Balto, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter be mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ettending physicien end for use es the burial-trensit The lew requires that the deeth certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the et id be deteched fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2 s 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifical completely filled in by the funeral director, I Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Nother (Specify) |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending iniun work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Chec only u D0071287 ess of person who completed cause of death (Item 23a) (Type, Print) where 6701 N. Charles F. 30. Name and address of person who think the Sua Veen MD, Dalthune, MD

Registrar

31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Day Physician/ 2012 Year 25, 10:47 A™ Brian Lamont Graddy, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 2108 Peaceful Way Unit 203 0denton If Under 1 Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours Min. (Month, Day, Year) Country) 149-52-8125 **Director** 1 X M 2 □ F 52 Usual Residence of Decedent Aug. 16, 1959 Pennsylvania r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 💢 No Maryland | Anne Arundel Odenton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō ms 23a or must be r 2108 Peaceful Way Unit 203 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. ь þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4X Divorced Completed **Black** Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) l Hygiene. Human Relations Elementary/Secondary (0-12) College (1-4 or 5+) the Department of Defense <u>Program Analyst</u> alth and Mental Hygie

27 is marked other

r traumatic event, the Be Page 1 and 2 should be filed vent of Health and Mental Hygent: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ernest Graddy, Jr. Shirley Arlene Isler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Clark Lane Stafford, Virginia 22554 LaToya T. Graddy / Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗓 Burial 2 🗌 Cremation 3 🗆 Removal from State August 02 ŏ Department of Important: If any injury or once. 2012 Sunset Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Pennsauken, New Jersey 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 21. Signature of Laneral Service Lice Part 1 Filter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inck, or heart failure. List only one cause on each line. DIABRIKS Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of the second of the se Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as consequence of) 10 BM -G-62 Exami burial-trar and resulting in death) Last Chackmic episones physician s the burial Physician/Medical 11. Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

2 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Day Year Month Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\frac{1}{2}\) Residence 6 \(\sum \) Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined the Hospital Medical Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 027566 7. 26.12 d cause of death (Item 23a) (Type, Print) Name and address of person who comp heverly MD 20785 DD State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0914 AM Ralph E. Goebel Medical Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death **Examiner** 4b. City, Town Ha NE MOR Social Security Number 8. Date of Birth 6. Sex Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Min (Month, Day, Year, 220-24-1032 **Director** 1 X M 2 D F Aug. 1, 1928 Maryland 83 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 XNo Baltimore Catonsville MD 10e Street and Number or 10f. Zip Code 10g. Citizen of What Country? ms 23a or 21228 USA 719 Maiden Choice Lane HRT 46 items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Medical Examiner Armed Forces? Black, White, etc. ò ģ 1 Never Married 2 Married White Maryland 21215-0036 If Yes, Give Year or Dates.1946–49 1 Yes 2X No Specify: Specify "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working vgiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Steel Manufacturing 12 Office Manager other t Be permit. Page 1 and 2 should be filed. Department of Health and Mental Humportant: If item 27 is merany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helene W. Dirzuweit George Goebel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
719 Maiden Choice Lane HRT46; Catonsville, MD 21228 Helen H. Goebel 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 8/1/2012 Atlantic Crematory Glen Burnie, MD 4 Donation 5 Other (Specify) Page and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician I for use as the buris Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 1 Tes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work?
1 Yes 2 No JOEB Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature d title of certifie 29d. Date signed (Month, Day, Year) 261 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Agres Hospital ED praton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 1 2012 parke Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Gassaway, Sr. 602 Abraham William 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ci If Under 1 Year I If Under 24 Hrs. Social Security Number Baltimore City 1Imore GASSAWAY Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 216-28-3011 Director 1 X M 2 D F 80 10/18/1931 Maryland Usual Residence of Decedent item 27 is marked other then "neturel", or items 23e or 28e-f shov other treumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Meryland Director 1 Yes 2 No Severna Park Anne Arundel Co Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 1304 Carroll Road United States William 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 K Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Korean Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pege 1 end 2 should be filed within 72 nent of Heelth end Mentel Hygiene. ant: If item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4 or 5+) Steel Company Millworker yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lillian Gassaway / Wife 1304 Carroll Road Severna Park, MD Depertment of Heelt Important: If item 2 eny Injury or other altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Haven Mem. Park 07/30/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of Surera Service Licens 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) days Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner • Hospitel or Attending Physicien: The lew requires that the death certilicate be executed to have after death.
• Funeral Director. After this certificate has been signed by the attending physicien and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit 4theroscleratic or Attending Physicien: The lew requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 V Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 30. Name and addr Baltimore 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Theodore Givens, Jr. 08:20 A.M Ju1v26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Healthcare Hammonds Lane Cntr Brooklyn Park Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 404-38-3283 Director 1 🛛 M 2 🗆 F 80 01/12/1932 Kentucky Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director Halethorpe Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21227 United States 4414 Scotia Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 🕅 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates. Korean 1 ☐ Yes 2 ☐XNo Specify: 3 🗌 Widowed 4 🗋 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Calibration Technician Westinghouse permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Williams L. Theodore Givens, Sr. Ruby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4414 Scotia Road Baltimore, MD Mrs. Beverley J. Givens / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗍 Removal from State Glen Haven Mem. Park 07/31/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation /≥.° Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Z) disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires that the death certificate be executed igned by the attending physician and be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate 2 🗆 No 1 🗌 Yes 2 🗓 funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After ifilled in by the funer Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certify 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Harwood <u> Mandrin Inpatient Care Center</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 12, 1966 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days Hours Min. Maryland Director 1 M 2 M 215-98-6134 46 Usual Residence of Decedent Show 10d. Inside City Limits 10b. County 10c. City, Town or Location th and Mental Hygiene. 27 is marked other then "netural", or items 23a or 28a-f sho treumatic event, the Modical Examiner must be notified at 10a. State Director 1 🗆 Yes 2 🖃 No Pasadena Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21122 8645 Cook Cobs Harbor filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Annable Susan Cherry Luther Becker Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any injury or other tree once. 8645 Cook Cobs Harbor Pasadena, Maryland 21122 Michael T. Graybill (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 07/28/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Loudon Park Cemetery 22. Name and Address of Facility Signature of Funeral Service Licensee MOO-732 McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a, Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirts, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use es the burial-transit Due to (or as a consequence of) resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☑ No 9 ☐ Unknown been signed by the s should be deteched 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: Hospital: 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

• Funeral Director: Aft bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated entifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier e of death (Item 23a) (Type Print) 0

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death James David Hetzer Month Physician/ 04:53AM 30 2012 alu Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford County **Examiner** 4b. City. Town, or Location of Death Upper Chesapeake Medical Center Bel Air Social Security Number 207–32–5733 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 02/24/1943 (Month, Day, Year) 1 X M 2 □ F Director 69 Pennsylvania Usual Residence of Decedent 28a-f shov 10c. City, Town or Location
Bel Air 10d. Inside City Limits must be notified at Director Maryland Harrford County 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country?
United States 9 Completed by Funeral 23a 21015 400 Tall Sycamore Court 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White If Yes, Give 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Beneficial Elementary/Secondary (0-12) College (1-4 or 5+) Manager Hygier other 1 Be 17. Father's Name (First, Middle, Last) David Coleman Hetzer Maryland 18. Mother's Name (First, Middle, Maiden Surname)
The Ima Fay Shaffer Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 400 Tall Sycanore Court, Bel Air, Maryland 21015 Erric Hetzer (Son) Health a or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Evans Funeral Chapel 08/02/2012 Forest Hill, Maryland 4 Donation 5 Other (Specify) Wars Funeral Chapel & Cremation Services 1 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licenses Jes Low 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Staphlococca disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any list ing to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of): the attending physician and hed for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: ျ 1 Inplatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

Natural

Accident 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 5 Pending iniury Investigation □ Acciden
 □ Suicide
 □ 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D0053568 500 uper resasenke 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ihon PYON 32. Registrar's S State Registrar

of Vital |

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DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (Eirst, Middle, Last) 2. Date of Death Physician/ OH Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Pearls of Wisdom Assisted Living Columbia Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 M 2 🗆 F Months Days Hours Washington, D.C. **Director** 89 578-22-0747 05 Usual Residence of Decedent 28a-f show death with the Maryland 10a, State 10b. County aţ 10c. City, Town or Location Director 10d. Inside City Limits notified 1 Yes 2 X No Maryland Howard Columbia ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be items 23a Funeral 21046 U.S.A. 9359 Guilford Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 2 🗌 No 1 ☐ Yes 2 🗷 No Specify: "natural", 3 Widowed 4 Divorced Specify Completed Black Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene, is marked other tha the Medical Doctor Psychiatry Be permit. Page 1 and 2 should be fille.
Department of Health and Mental Hv.
Important: If item 27 is marany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Esther Viola Marshall Hawes Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3573 17th Street San Francisco, CA 94110 John M. Hamilton, Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State National Hannony Memorial 8-4-2012 4 Donation 5 Other (Specify) Hyattsville, Maryland Signature of Fyneral Service Lice Lee Witzke Funeral Homes, Inc 22. Name and Address of Facility 5555 Twin Knolls Road Columbia, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to lur as an and burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as 1 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atte in the past 12 months? Dav Pregnant at time of death Yes 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has page 2 autopsy prior to completion of cause of death? perforn certificate 1 Yes Yes 2 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: ည 1 Tyes 2 No 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral di filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit 29d. Date signed (Month Day, Year) who completed cause of death (Item 23a) (Type, Print) State Registrar

HMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g930 8-2-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Robert Lawrence Huether July 8:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 618 Regester Ave Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 218-80-5974 9/18/1958 MaryTand **Director** 1 X M 2 - F 53 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a. any injury or other traumatic event, the Medical Examiner must bb Funeral 21212 U.S.A. 618 Regester Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married 2 1 ☐ Yes 2 XXNo If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Vice President Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Calvin Huether Ruth Tremmel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code DOD 7/27/2012 Maureen Ann Huether / Wife 618 Regester Ave. Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Hilltop Serv. Corp. 7/30/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 0 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death tumor fancientic Physician Netastatic Neuroandocure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami physician and s the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
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The Funeral Director: After this ce Other: 4 Nursing Home 5 🕅 Residence 6 Nother (Specify) Hospital: 2 XV0 မ 1 Tes Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate (Month, Day, Year) 12 Natural 5 Pending injury 1 Yes 2 No 2 Accider
3 Suicide Accident Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie Be gral 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRB1-4M08 1650 Orleans Balhmore OM 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

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		Usual Residence of Decedent	1 □ M 2 🛛 F	96	Yrs.					Aug 5	, 193	15	Mar	yland	
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if firem 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marri</li><li>3 ☒ Widowed 4 ☐ Divorced</li></ul>	12. Was Deceden Armed Forces 1  Yes 2 If Yes, Give Year or Dates.	?	lf	Vas Deced Yes, spec				cify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White, e		
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Ruth Hatzman

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 22, Holman Anna ŽÕ12 7:15 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 197 Greenland Beach Road Greenland Beach Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, April 23, 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 1 □ M 2 🗗 F Hours 213-34-6846 86 1926 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Greenland Beach 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 197 Greenland Beach Road 21226 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 N/A Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Seitz Martin Katharina Enders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Haithcock (Daughter) 197 Greenland Beach Road Greenland Beach, Maryland 21226 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 07/26/2012 Glen Burnie, Maryland Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Folyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liviny or other traumatic event, the Mudical Experiment must be notified at once.

**Physician** /Medical Examiner

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After this certification funeral director, p

Baltimore, Maryland 21215-0036

	Immediate Cause (Final disease or condition resulting in death)	a. CORONARY A  Due to (or as a consequence of):		ISEASE	Onset and Death
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.	BSTRUCH	VEKRYC	WARY DISEASE
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2▼No 9 □ Unknown		pic pregnancy er (specify)		23d. Date of delivery Month Day Year
ted by PI	Part II. Other significant conditions of	contributing to leath but not resulting in the underlying	ing cause given in Part I.		se contribute to the cause of death?  No 3 Probably 4 Unknown
Comple				24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	Other	ath (Check only one)	
Medical Certification: To	27. Manner of Death  11 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	Home SX Residence 6 28d. Describe how injury	
Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, far building, etc. (Specify)	ctory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
ledical	one)	nysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investig and manner stated	irred at the time, date and plac ation, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)
2	29b. Signature applytitle of certifier	ELLMID	29c. License number  DOOZ	5/9 29d. Dat	e signed (Month, Day, Year)
	KICHARD & FI		RITCHIE H	WAY E	SROOKLYN ZRZ
e	31. Date filed (Month, Day, Year)	32. Registrar's Signature			

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State

Registrar

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12-03303	P	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
Ryan Imwold		State of Maryland / Department of Health and Mental Hygiene
	1- For State	0 - 4:5 - 4 5 D 41-

		Registrar	cate of	Death			Reg. No.	
hysician/ Medi Exam						2. Date of Dea Month July 23, 2	Day Year	3. Time of Death 1000 hrs
,		4a. Facility Name (if not institution, give street and number) Frederick Memorial Hospital	1	b. City, Town, or l rederick	ocation of Death		4c. County of De Frederick	ath
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days				Birthplace (State or Foreign Country) Iaryland
<b>&gt;</b>		Usual Residence of Decedent		!				
Maryland 28a-f show any	or	10a. State	m or Locetic erick	n				10d. Inside City Limits  1 Yes 2 No
E g	Director	10e. Street and Number 208 Harpers Way		10f. Zip Code 2170	2		10g Citizen of What Co USA	ountry?
ath with th items 23a	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?		Decedent of Hisp es, specify Cuban			14. Race - Am White, etc	erican Indian, Black,
after de	by Fu	3 Widowed 4 Divorced If Yes, Sive Year on Dates:		Yes 2 🔀 No			Specify: W	
72 hours afte n "natural",	pa	15. Decedent's Education (Specify only highest grade completed) 16a  Elementary/Secondary (0-12) College (1-4 or 5+)	a. Decedent's during mo	s Usual Occupationst of working life.	n (Give kind of w DO NOT use reti	ork done red)	16b. Kind of Busines	s/Industry
5-0036 lled within 72 Hygiene I other than	Complet	1	Field	d Superv			Tile	
e, MD 21215-003 1 and 2 should be filed with Health and Mental Hygiene iten 27 is marked other ti or treumatic event, the Ma	Be	17 Father's Name (First, Middle, Last) Philip Anthony Imwold			Susan	Regina		
b, MD 21. and 2 should the lealth and Mer tern 27 is mar traumatic ever	7						nber, City or Town, Sta	
		20a. Method of Disposition 20b. Place		on (Name of cem	· ·	Date	20c. Location - City	
Baltimore, permit. Pages 1 ar Department of Hez Important: If the			owride	ge Mem. ]	Park 7/3	1/2012	Elkridge,	MD
Ba perm Depa Impo injur		MS K. Hadena Moroso	Ful 16	neral Ho 30 Edmon	me of Ca dson Ave	atonsvi	Ashton Sch lle, Inc. atonsville	MD 21228
Physician /Medical		23a. Part I. Efter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	ot enter the i	mode of dying, su	ch as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a <b>Atherosclerotic</b> Due to (or as a consequence of):	Cardi	ovascu1a	r Disea	se		Death
	e	Sequentially list conditions, if any, leading to immediat:  Due to (or as a gunse painte of):				-		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use to for as a consequence or).						
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68760, ertificate be executed ding physician and eas the buriat - transi	an/Medical	X UNPENDED X AMENDED 23a, 27, per 29, 30, per 15 FEMALE: 23c. If yes, outcome of pregnance	me,g	930 8-14 931 9-5-	-12 sm -12 vt		23d. Date of delive	ory
0 4 3	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of death	2 Feta	ideath 3	Ectopic pregna	incy	Month	Day Yeer
Box of death of the attented for us	Physici	1 Yes 2 No 9 Unknown 9 Unknown		r (Specify)				
res that the signed by it be detach	ā	Part II. Other significant conditions contributing to death but not resulting	ig in the u <b>n</b> d	erlying cause give	n in Part I.		obacco use contribute t s 2 No 3 Pr	o the cause of death? obably 4 X Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been seed in by the funeral director, page 2 should to	Completed					24a. Was auto		autopsy findings available o completion of cause of
tal Rection: The lacentificate ha	S					1 X Yes	ormed? death? 2 No 1 X	
Vital hysician: this certi	Be	25. Was case referred to medicel examiner?  1 NYes 2 No Hospital 1 Inpatient 2 X ER/C	Outpatient		of Deeth (Check		Residence 6 Oth	er:
n of Ing Phy After the	n: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b	. Time of Inj	ury 28c. Injury		28d. Describe	how injury occurred	
Sior Attend or death rector: by the	catic	2 Accident Investigation 28e Place of Injury - At home	farm street		es 2 No	28t Locetion (	Street end Number or F	tural Route Number, City
Divis  Putal or At  ours after of  neral Durec filled in by	CertIfication:	4 Homicide determined (Specify)				or Town.		ara reado randor, ony
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Runeral Director: After this certificate has been signed by the after completely filled in by the funeral director, page 2 should be detached for u.	ledical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.						
Ē ¥ Ē S	Me	29b Signature and title of certifier Pamela E. South		29c. License		r a =	29d. Date signed (A	fonth, Day, Year)
(5)		there we with JE	MD.	O.C.N	I. I	5ME	July 24, 2012	
		30 Name and address of person who completed cause of digath (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Exami	Par iner 90	<b>me1a E.</b> 0 W. Baltimor	Southal: e Street, Bal	<b>l, MD.</b> timore, MD 2	21223	
St Regist	ate rar	31. Date filed (Month, Day, Year) 37. Registrer's Signature	6. 4		<u> </u>		and the state of t	
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68766

aumatic event, the Maileat Examiner author position at the Maileat Examiner author position at the mailean and the mailean at	5. Social Security Number 213-34-6006  Usual Residence of Decedent 10a. State 10b. County  Maryland Anne Arur 10e. Street and Number 432 5th Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)  Douglas Johns 19a. Informant's Name/Relationship (Ty,	7. Age (IIII)  7. Age (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	n yrs. last birth 76 Noc. City, Town	or Location  10f. Zi  13. Was Decriffyes, spi 1 □ Yes	Broo	Location of Death  Ly Por  HUnder 24 Hrs.  Hours Min.  klyn  21225  Ispanic Origin? (Spen, Mexican, Puerto Specify:	2. Date of Dea Month  JULY  8. Date of Birtt (Month, Day  Aug. 23	Day 4c. Co 4c. Co 7, 1935	n of What Co Inited	thplace (State or Fore unitry) Virgini  10d. Inside City Lim 1  Yes  1	
reminer and remaining and rema	Anne Arur	7. Age (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	n yrs. last birti 76 ) Oc. City, Town	or Location  10f. Zi  13. Was Decelf Yes, spi 1 Yes  Decedent's Usi (Give kind of wife, DO NOT)	Broo ip Code  edent of Hierory Coulomb Agents of Hierory Coulomb	Hours Min.  klyn  21225  Ispanic Origin? (Sp. Nexican, Puerto Specify:	8. Date of Birth (Month, Day Aug 23	, 1935 10g. Citizer U	9. Bird Co	th Arms thiplace (State or Forestuntry) Virgini  10d. Inside City Lim 1 Yes 201  buntry?  States  brican Indian, e, etc.	
in terms coact store and coact	Juliar Residence of Decedent  Juliar Residence of Decedent  Juliar Residence of Decedent  Juliar Pland Anne Arun  Juliar A	ndel  12. Was Decedent Ever Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates: cation e completed)	r in U.S.	or Location  10f. Zi  13. Was Deceler (If Yes, spin 1 Yes)  Decedent's Using (Give kind of willer, DO NOT)	Broo ip Code edent of Hi ecify Cuba 2 No ual Occupa	klyn 21225 Ispanic Origin? (Sp. n, Mexican, Puerto Specify:		10g. Citizer U 14.	n of What Co Inited Race - Ame Black, White	10d. Inside City Lim 1 Yes 200	
To Be Completed by Funeral Director	Maryland Anne Arur  10e. Street and Number  432 5th Avenue  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ  (Specify only highest grade  Elementary/Secondary (0-12)  10  11. Father's Name (First, Middle, Last)  Douglas Johns  19a. Informant's Name/Relationship (Ty)	12. Was Decedent Ever Armed Forces? 1   Yes 2   No If Yes, Give Year or Dates:	r in U.S.	10f. Zi 13. Was Dece If Yes, sp 1 □ Yes  Decedent's Usi (Give kind of w life, DO NOT)	edent of Hi ecify Cuba  2X No  ual Occupa	21225 Ispanic Origin? (Spn, Mexican, Puerto		14.	nited Race - Ame Black, White	untry?  States  Storican Indian, e, etc.	
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To Be Co	17. Father's Name (First, Middle, Last) Douglas Johns  19a. Informant's Name/Relationship (Ty)					)	king		of Business aurant		
ar trauma						18. Mother's Nam Sadie	e (First, Middle, Adcock	Maiden Su	rname)		
<u> </u>	Carol Ann Mick/Daughter  432 5th Avenue, Brooklyn, Maryland 21225  20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or T										
Injury or ot		lemoval from State	Metro	Cremato	ry Ir	10. 07/2	6/2012	Balti	more,	Maryland Maryland	
	23a. Part1. Enter the disease, or compli	Lon		299 Fr	ederi	ick Road,	Baltime	ore, l	Maryla	and 21228  Approximate	
urial-transit and leading lead	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence o	of):	esu	Cohnon	gris	uy		Onset and Death 2 who	
etached for use as the b	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Live birth 2   Fetal death 3   Ectopic pregnancy   23d. D   No 9   Unknown   9   Unknown   9   Unknown   1   Live birth 2   Fetal death 3   Ectopic pregnancy   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Fetal death 5   Other (specify)   No 9   Unknown   1   Live birth 2   Liv									elivery Day Year	
be d	Part II. Other significant conditions cor		ot resulting in		2	en in Part I.				o the cause of death	
rector, page 2 should b							24a. Was autop perfor	rmed?		utopsy findings availa completion of cause s 2 □No	
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completely filled in by the funeral director, r Medical Certification: To Be C	27. Manner of Death 1	28a. Date of Injury (Month, Day, Yo	28b. 1	ime of njury	28c. Injur Work	v at	28d. Describe h			ecny)	
illed in by the funera  Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	Specify)				City or Tou	vn, State)		lural Route Number,	
edical		sician: To the best of r iner: On the basis of ex and manner stated	xamination an								
M M	29b. Signature and title of certifier	m n	n		9c. Licens		1			ith, Day, Year)	
4	30. Name and address of person who co	ompleted cause of deat	th (Item 23a)	(Type, Print)	431	70555 Fur B	- Ba	th,	no	2/176	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** July 9:30 p HENRY 27 2012 JAMES **JOHNSON** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD CO. BEL ATR If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 1224 TUSCANY LANE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 X M 2 ☐ F AUG. 9 1920 VIRGÍNIA 230-01-3498 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2\OXNo Director BEL AIR MARYLAND HARFORD CO. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1224 TUSCANY LANE 21014 Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 DYes 2 □ No 44/46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: BLACK If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. POSTAL SERVICE LETTER CARRIER 12yrs. l yr 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARY JOHNSON 2 BENJAMIN F. JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1224 Tuscany Lane, Bel Air, Md., 21014 James E. Johnson/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-04-12 NEWPORT NEWS, VIRGINIA GREENLAWN CEMETERY <sup>¹</sup> 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME-HARFORD, PA. 21. Signature of Funera Service Licenses 321 S PHILA, BLVD, ABERDEEN, MD 21001 Approximate Interval Between Onset and Death 26. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Renal Stage ( disease or condition resulting in death) hypertension pue to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day Year Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown Dementia Congestive heart failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hep B positive 25. Was ase referred to medical examiner? 1 Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation

be executed Box 68760 physician the Records, P.O. ģ Division of Vital death.

**Funeral** 

Director

or 28a-f show iner rust be notified at

or Items 23£

Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene.
ant: If item 27 is marked other then "neturel", or iter ary or other treumatic event, the Medical Examiliar.

permit. Page Department of Important: If eny injury or once.

Physician

/Medical Examiner

death

21215-0036

Baltimore, Maryland

þ Completed Be 2 Certification:

Medical

3 Suicide

29a. Certifier

4 Thomicide

(Check only one)

Director: To the Hospitel within 24 hours a To the Funerel C

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D0046907

Bel Air

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who comp eted cause of death (Item 23a) (Type, Print)

Chesapeake Dr. upper 5-20 32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g930 8-13-12 yt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HAROLD JOHNSON JR. JULY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 5. Social Security Numbe 6768 Sex 1XXM 2 □ F . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Country IRGINIA Director 78 29 219-28<del>-6788</del> TIIT Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2**XX**No MARYLAND HARFORD CO **JOPPA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14 BRIDGE DRIVE 21085 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 57/59 Specify: BLACK 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 72 permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) FORMAN & MECHANIC 7th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES H. JOHNSON SR. AGNES JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Bridge Dr., Joppa, Maryland 21085 Sedonia Johnson/Wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State METRO CREMATORY 07/31/12 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Fun - 1 Sirvi e 22. Name and Address of Facility COMM FUNERAL HOME-HARFORD, P.A. 321 S PHILA. BLVB., ABERDEEN, MD., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. RENAL Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death page 2 should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dinknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy death? 2 A No 2 🗌 No 1 🗌 Yes Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DQA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕻 Natural injury 5 Pending after death. 1 Yes 2 No Investigation 2 Accident
3 Suicide
4 Homicide Accident the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by determined City or Town, State 24 hours Medical 🔥 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my line weeds on well-occurred at the time, date on or place, and oue to the cause(s) and manner stated. (Check within 2 MARY LAND HEALTH CAKE SYSTEM, PERRY POINT, MD 1901

DHMH 17 Rev 7/2009

State Registrar ULLUEK

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Edna Janis July 29, 8:50 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8734 Millers Island Road Baltimore Sparrows Point Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F 213-14-3915 April 26, 1923 Months Days Hours Director 89 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. Counts with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified Md. Baltimore Sparrows Point 1 🗌 Yes 2 🗶 No 10e. Street and Numbe 5 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 8734 Millers Island Road 21219 LISA death v Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black White etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🏖 No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify White "natural" 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Housewife Own Home 10 years Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Holthause Ann Phelps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel White Daughter 8734 Millers Island Road, Sparrows Point, Md. 21219 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o August 2, 1 ★ Burial 2 Cremation 3 Removal from State Sykesville, Maryland Lakeview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service Licens Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Pax 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Cardiony Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 8 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 00059 Name and address of person who completed cause of death (Item 23a) (Type, Print) 505 2122 Hanking State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND PI, LINE BEC of PII PER MD 6929 7/31/12 at TBT Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ S:05 201 Medical Facility Name Town, or Location of Death County of Death if not institution, give street and number, City **Examiner** Date of bill.
(Month, Day, Year) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 D Month: Min. 69 Yrs **Director** 214-42-1901 1943 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 r items 23a or ner must be n Funeral 4100 West Overlea Avenue 21206 United States death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No "natural", or iter If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Ment. Important if item 27 is marked any injury or a should be any injury or a should be a sho 2 Agnes Bolewicki Joseph John Kozlowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Kozlowski /Brother 4100 West Overlea Avenue Baltimore, MD 21206 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Jul Beltsville, Maryland 4 Donation 5 Other (Specify) 2012 Chesapeake Crematory 22. Narcremation Famu Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, n each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CARDIOMYOPATHY, ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) nding physician and use as the burial-transit CORONARY ARTERY DISEASE Due to (or as a consequence of) Physician/Medical requires that the death certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy the atter in the past 12 months?
1 Yes 2 No for Month Pregnant at time of death Other (specify) signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Nown Division of Vital Records, CELLULITIS should I Completed Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 s 24 hours after death.
Funeral Director: After this certificate has autopsy perforn 1 Yes 2 No Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner' P Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Merci JUL 3 1 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12:24 AM Jul SNIGHI Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore FutureCare- Cherrywood Reisterstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2X F Director 577-46-4379 Yrs 79 4-3-1933 DC ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Funeral Director 1 Yes 2 No M) **Baltimore** Randallstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a o I Examiner must be 211.33 USA 4 Geier Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Specify: African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural". 3 Widowed 4 Divorced Completed Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natur ury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) C & P Service Representative Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Goldie Brady Robert Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl L. Knight/ Husband 4 Geier Ct., Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of P Important: If it any injury or o once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 7-31-2012 Woodlawn, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Firemal Home P.A. of Balto. Co. Signature Funeral Service Lice 9200 Liberty Rd., Randallstown, MD 21133 23a- Fart 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Chronic Obstructive Pulsionny Onset and Death F7systetan/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last ding physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b þ LUNG MASS 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? 1 Yes 2 No this certificate **Division of Vital** To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 - No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number R088852 10m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solisbury, NAMY INS 21802 C. DIAMONS P.O. BOX 26/3 KATHUSSN

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

31

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth 07 Carl Franklin Keener, Jr. 2012 5:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 24 Hrs. . Sex 1 🕅 M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. MO2/88/1925 County aryland 217-12-3065 87 Director Usual Residence of Decedent show of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 ☐ No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12236 Roundwood Road, Unit 610 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black. White, etc. 1 Never Married 2 Married 2 □ Navy Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bay Pilot Transportation Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Carl Franklin Keener, Sr. Etta Marie Gibble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Lorie O'Malia / Daughter 919 Deer Court, Abingdon, MD 21009 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 7/29/2012 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events Exami or Attending Physician: The law requires that the death certificate be executed after death. -tran and resulting in death) Last Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 - Unknown 1 ☐ Yes 2 ☐ No 3 ( To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director, After this certificale has been sompleted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 🛚 ျ 1 Inpatient 2 I ER/Outpatient 3 4 Nursing Home 5 Residence 6 NOther (Sp. 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident Pending 1 Tes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Kimmel Ronetta King 20:55P <sup>™</sup> 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Months Hours Director 128-58-1942 1 M 2 XF 45 04/05/1967 NYC, NY ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 🔀 No Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral , or items 23a 9623 Muirkirk Rd. 20708 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify:Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) DC Government Accounting Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ronald Norfork Barbara King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Courtney King, brother Van Pelt Ave. Staten Island. NY 10303 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fairlawn Mem. Cem. 8/6/2012 | Fairlawn, N.J. 4 Donation 5 Qth 21. Signature of Funeral Service 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Rd. Temple Hills. MD 23a. Part 1. Enter the disease, of shock, or heart failure. List of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death only one cause on each line Immediate Cause (Final Physician/ Metaska disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Pregnant at time of death signed by the at d be detached for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 certificate 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 19 No မ 1 III Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide filled in by the Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 069297 27 hysiagn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rosa Ducken 20707 31. Date filed (Month, Day, Year) 32. Registrar State 3 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Kordek Richard F. 2012 2:05 PM July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Gilchrist Hospice Center Towson . Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 214-38-9170 1 X M 2 D F Dec. 20,1941 70 Maryland Usual Residence of Deced 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Harford Abingdon 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21009 United States 3814 Washington Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Year or Dates. Vietnam White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Baker A & P Supermarkets Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ည Evelyn DiAngelo Francis Kordek f Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3814 Washington Ave. Abingdon, MD Mrs. Diane J. Kordek (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 Durial 2 X Cremation 3 D Removal from State Hilltop Service Corp. 7/27/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Christine Hilton <sup>22</sup> Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Marvland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease Or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by filled in by the funeral director, page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \subseteq \text{ Nursing Home } 5 \subseteq \text{ Residence } 6 \text{ Other (Specify) \( \text{VITP(U)} \) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural
Accident 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital c within 24 hours af To the Funeral Di Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one cause of death (Item 23a) (Type, Print) MO 6701 Yĕar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	ryland				d Mental Hy	giene	2012	24175
			State Registrar			Cer	tificate of D	Death		Reg. No.	012	27110
	Physicia	n/	Decedent's Name (First, Middle, Last)						Date of De     Month	ath Day	Year	3. Time of Death
	Medic	al	Louise Riebe  4a. Facility Name (if not institution, give st	Klink			45 00 75	Leasting of De	July_		012	10:15 A M
	Examin	er	926 Sunnybrook Dri				4b. City, Town, or Glen Bi		atn		ounty of Death	undel Co.
19.60	Funeral		5. Social Security Number 6. Sex		(In yrs. last	birthday)	If Under 1 Year	If Under 24 H		th	9. Birth	place (State or Foreign
н	Director		219-28-9724	м 2ХД г	0.1	Yrs.	Months Days	Hours Mi			PA	ntry)
	MO #		Usual Residence of Decedent  10a, State  10b. County		81 10c. City, T		-No-		11/05/	1930		404 114-03-11-15-
	rylan	Director										10d. Inside City Limits  1 ☐ Yes 2 汉汉vo
	r 28e	Pire	MD Anne Aru  10e. Street and Number	indel	Glen	Burn	10f. Zip Code		- 1	10a Citize	n of What Cou	
	vith th		926 Sunnybrook Dri	ve			21060			USA		niay.
	eath v	Funeral		2. Was Decedent Ev	er in U.S.	13. V	/as Decedent of His	spanic Origin?	(Specify Yes or No-	14.	. Race - Ameri	can Indian,
9	or li	اج	1 ☐ Never Married XX Married	Armed Forces?  1  Yes 2	lo	- 1	Yes, specify Cubar  ☐ Yes XX No		erto Rican, etc.)		Black, White,	
8	urs a	Completed	3 Widowed 4 Divorced	Year or Dates.						Sp	ecify: Wh:	ite
5	72 ho "na" r		15. Decedent's Edu (Specify only highest grad		111	(Give k	ent's Usual Occupa ind of work done d O NOT use retired)	ation <i>luring most of</i> w	vorking	16b. Kind	of Business/Ir	ndustry
12	rithin iene. r tha	ខ្ញ	Elementary/Secondary (0-12)	College (1-4 or 5+	)	Cler				So	cial S	ecurity
b	iled w		17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Middle,			
/ar	Jenta Jenta Irked Itlc ev	잍	John Smith Bra	ıy				01ive	Hermer	na R	iebe	
an	shoulk and h Is ma	Ш	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailin	g Address (Street a	and Number or	Rural Route Numbe	er, City or To	wn, State, Zip	Code)
≥,	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumate event, the Medical Examiner must be notified at		Mr. John Klink / Hu	isband	$\perp$		Sunnybro	ok Driv			e, MD	
Ore	or oth		20a. Method of Disposition 1 ☐ Burial ※XX Cremation 3 ☐ F	emoval from State	20b. Plac cem	ce of Dispos netery, crem	sition (Name of natory or other place		Date		ition - City or T	
Baltimore, Maryland 21215-0036	it. Pag rtmer rtant njury		4 Donation 5 Other (Specify)		Atla		Cremator		31/2012		Burni	
Ba	permit. Page 1. Department of I Important: If it any Injury or of		21. Signatury of Funeral Savyout Icensed	No.22	-0	- 1	Name and Addres					Cremation e, MD 21061
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one		the death. [		The second second				F	Approximate Interval Between
	nysician/		Immediate Cause (Final disease or condition		Fe,	10	e to	The	ie			Onset and Death
No.	Medical Examiner		resulting in death)	Due to (or as a	consequen	ice of):	e fo	* 7	-			
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a			ejular	11	12000			
	ed nsit	Examine	cause. Enter Underlying Cause (Disease or injury	Due to for as a	consequen	ice oi).						
	death certificate be executed ne attending physician and ed for use as the burial-transit	Exa	that initiated events cresulting in death) Last	Due to (or as a	consequen	ice of):						
09	yslcia yslcia	dical		l								
876	tificat ng ph as th	Med	IF FEMALE:									
Box 687	tendir tendir or use	an/	23b. Was decedent pregnant in the past 12 months?		Fetal d	leath 3 🗌	Ectopic pregnanc	у		230	d. Date of deli	
	ss that the death certifics igned by the attending p be detached for use as	Physician/Me	1 Yes 2 De No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of dea	ath 5∟	Other (specify)				Month	Day Year
P.0.	The law requires that the ate has been signed by tipage 2 should be detach		Part II. Other significant conditions con	tributing to death bu	t not resulti	ing in the u	ndertying cause giv	en in Part I.	23e. Did 1	obacco use	contribute to	the cause of death?
	ires t sign	Completed by	1)10	belee,	Me	111	41		_ 1 🗆	Yes 2 □	No 3₽Pro	obably 4 Unknown
ord	v require s been si should	Set	For	11.10	100				24a. Was			opsy findings available
3ec	hysician: The law r his certificate has b il director, page 2 s	E	6/0	mus A	Wer.	46	21100.10	_		psy ormed? 2 No	death?	ompletion of cause of
a	lan: T rrifica ctor, p	Be C	25. Was case referred to medical examiner?			14 IV	26. Pla	ace of Death (C		2 (2 140)		NEW COLUMN
Ξ	hysic his ce al dire	욘	1 ☐ Yes 2 ☑ No	ospital: 1			t 3 DOA Othe	er: 4 🗌 Nursin	Home 5 Resi	dence 6 🗆	Other (Specif	(y)
9	Attending Physician: ir death. ector: After this certific by the funeral director,	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		Bb. Time of injury	28c. Injury work	?	28d. Describe	how injury o	ccurred	
sior	ttenc death ctor: / y the	≌	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	ov - At home	e farm etre		Yes 2 □ No	29f Location (	Street and N	lumbar ar Pum	al Route Number,
Division of Vital Records,	alor A s after Il Direct		4 ☐ Homicide determined	building, etc.		o, iaiii, siic	et, lactory, office		City or To		uniber of Hure	as noble Number,
_	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physic (Check conty one) 3 Certifying Nurse	er: On the basis of ex	amination a	nd/or invest	igation, in my opinio	on, death occum	ed at the time, date	and place, ar	nd due to the ca	ause(s) and manner stated.
	To the within 2 To the complete	2	29b. Signature and title of certifier	would ref. to the	Jose of thy		29c. License	number		29d. Date s	signed (Month,	Day, Year)
				- 1	1-0		05	5506		01	7/27	112
			30. Name and address of person who co	mpleted cause of de	ath (Item 23	3a) (Type, P	rint)	Luy	6 len A	2/2.	· 16.	12 ylor 12/06,
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	е						
	Registr	ar	JUL 3 1 2012 Dene	m A.	park							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Harold Lloyd Kipe Sr. 10:00AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Sykesville Transitions Healthcare If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 Months 09/05/1930 214-28-5831 81 Director MD Usual Residence of Decedent f show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Reisterstown 1 Yes 2 No Carroll MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21136 Lawndale Road 3492 E. be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces?

1 Ness 2 No 1951If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify:White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Supervisor 10 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ Annie E. Davis t. Page 1 and 2 should be rtment of Health and Men rtant: If item 27 is marke njury or other traumatic Hiriam W. Kipe Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3492 Lawndale Rd. Reisterstown, Md., 21136 Erma Kipe-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 7/31/12 Emory U.M.C Cem Upperco 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home, P.A. Signator Fugural Service Licenses 254 E. Main St., Westminster, Md., 21157 23a. Part 1. Differ the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of Examiner Mente Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death 2 No 1 Yes 2 9 Unknown been signed by the should be detached 9 I Ilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed' Hospital or Attending Physician: The 2 1NO 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work: 2 Accident
3 Suicide
4 Homicide M 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🕒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D - 0054218

Registrar DHMH 17 Rev 7/2009

State

Raman

31. Date filed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print)

A MAN B. KAYEY 349 Malcalm duke

Kaneur

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First\_Middle\_Last) 2. Date of Death 3. Time of Death Physician/ Charlotte M. Korman 2012 5:51 p <sup>M</sup> July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Davs Hours (Month, Day, Year) **Director** 218-18-6823 1 □ M 2 🖾 F 91 Feb 14, 1921 Maryland ar than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Carrol1 Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1804 Doe Drive 21048 U.S.A. filad within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Waitress Restaurant Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should ba filar and Mental H ည permit. Paga 1 and 2 should ba Department of Health and Meni Important: If item 27 is marke any Injury or othar traumatic once. Joshua Peeling Beulah Grim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7254 Snow Drive Englewood, Florida Michael Korman Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Carroll Cremation Inc 7/30/12 Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Lus leer ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) COLON CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): tor: After this certificate has bean signad by the attending physician and the funeral director, page 2 should be detached for use as the burlal-transit oc (Disease of itijuty that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical a Hospital or Attanding Physician: The law requires that the death cartificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attention had also been signed by the attention had a second been second by the attention had a second been second by the attention had a Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) HOSPICE 1 Yes 2 X No မူ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation To the Hospital or Attal within 24 hours after de:
To the Funeral Director complately filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X Continued Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner stated. only one 29b. Signature and title o 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) Barket Registrar

CHARLOTTE

OHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 29,2012 6:30 A.M VICTORIA BARBARA KOGELSCHATZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner PHOENIX** BALTIMORE 3815 SWEET AIR ROAD If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) Director 213-20-6733 1 M 2 X F 86 8-15-1925 **MARYLAND** Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director 3a or 28a-f sh t be notified a 1 🗌 Yes 2 🙀 No BALTO. **PHOENIX** MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral "natural", or items 23/ edical Examiner must USA 3815 SWEET AIR ROAD 21131 death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after WHITE 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify 3 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOME 12TH HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 MATILDA RUTKOWSKI JOHN MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRY KOGELSCHATZ **SPOUSE** 3815 SWEET AIR ROAD PHOENIX, MD. 21131 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State ST. JOHN'S LUTHERAN 8-3-2012 PHOENIX, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. Signature of Funeral Service Licensee Laure 9705 BELATE ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Breast One t and Death Immediate Cause (Final Lonce Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 as the b IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Yes Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, No Hospital or Attending Physician: The law requires 3 Probably 4 Unknown 1 Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy has 1 ☐ Yes 2 🔀 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 X No ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After the din by the funeral Certificate: 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifie 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 03452 (ans) rson who completed cause of death (Nem 234) (Type, Print) DR. MARK 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DOROTHY MARGARET KIDWELL Month 7:22 Physician July 25 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dundalk Baltimore Futurecare - Northpoint If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 14, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🛛 F 208-22-9376 93 Yrs 1918 Pennsylvania Director Usual Residence of Decedent the Maryland 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examirer must be redified at 1 ☐ Yes 21 No Director Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 1920 Ormand Road 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify. þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife & Mother Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Sanders Mary Elizabeth Mentzer မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rose Madison 902-F Martell Court, Bel Air, Maryland 21014-6858 (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loretto, Pennsylvania St. Michael's Cemetery 7/30/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Folyniak Funeral Home, P.A. 21. Signature of Funeral/Bervice Licensee Kevin E Ecker 130 East Fort Avenue, Baltimore, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final andico Who **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Known Tongon if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2 ☑No 9 Unknown Part II. Other significant conditions contributing to death but not, resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Onknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 212 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1.□Natural 1 ☐ Yes 2 ☐ No after death completely filled in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NASBRM.

M-D

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Fog.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0-38754

BASTERN BLUD

29d. Date signed (Month, Day, Year)

-26-2012.

MD \_ 2/22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			for State of Mary				Mental Hy	giene	0 0110	
		_	Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of L	Death		Reg. No.	2 2418	
ı	Physicia Medic		Ann Dudley Lalley				2. Date of Dea Month July	26 201	3. Time of Death 2 4:05 PM	
$\supset$	Examir	er	4a. Facility Name (If not institution, give street and number)  Presbyterian Home of MD		4b. City, Town, or Towson	Location of Death	1	4c. County of Dea Baltimor	th Ce	
	Funeral Director		2/18-1/1-055/1	yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days					
	ryland I-f show Ied at	Director		c. City, Town or Loc Naples	cation				10d. Inside City Limits 1 X Yes 2 □ No	
	the Ma a or 28a be notif	al Dire	10e. Street and Number	Мартев	10f. Zip Code			10g. Citizen of What C	ountry?	
	eath with	Funeral	2905 Gulf Shore Blvd. N  11. Marital Status 12. Was Decedent Ever i	in U.S. 13. V	34103 Vas Decedent of Hi	spanic Origin? (Sp		United Sta		
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.		Yes, specify Cuba		Rican, etc.)	Black, Whit		
215-0	an "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k	ent's Usual Occupa kind of work done of NOT use retired)		king	16b. Kind of Business	/Industry	
21,	withing giene ger the the the		College (1-4 or 5+)	ŀ	nomemaker			own home		
Baltimore, Maryland 21215-0036	d 2 should be filed vaith and Mental Hyg alth and Mental Hyg 27 is marked othe er traumatic event,	To Be	17. Father's Name (First, Middle, Last) Arthur Maxwell Field				ne (First, Middle, I e Bartor	,		
Man	d 2 should alth and I	5	19a. Informant's Name/Relationship (Type, Print) Thomas Lalley/son		g Address (Street a			City or Town, State, Zi	p Code) 21204	
nore,	ige 1 and nt of Hea t: If item		1 Burial 2 X Cremation 3 Removal from State	0b. Place of Dispos cemetery, crem	sition (Name of natory or other plac	e)	Date	20c. Location - City or		
altin	permit. Pa Departme Importan any injury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	etro Crem				Baltimore,		
ш	20 E # 9	1	July 8. Mitchell					Home, Inc MD 21212	•	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as spock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition							or respiratory arre	est,	Approximate Interval Between Onset and Death	
	Medical Examiner	_	resulting in death)  Due to (or as a con Sequentially list conditions,	sequence of):						
	ted d ansit	Examiner	if any, leading to immediate Due to (or as a con cause. Enter Underlying Cause (Lisease or injury	sequence of):						
09.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Ex	that initiated events resulting in death) Last  C. Due to (or as a conduction of the	sequence of):						
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Division of Vital	nding Ph ath. r: After thi se funeral	Certificate: 1	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation  28a. Date of injury (Month, Day, Yea	28b. Time of	28c. Injury work	at		ow injury occurred	nry)	
Division	al or Atte s after de Il Directo ed in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, stree ecify)	et, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,	
_	he <b>Hospit</b> in 24 hour he <b>Funera</b> pletely fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my king the control of the desis of examiners on the basis of examiners on the basis of examiners on the basis of examiners. To the best of my king the control of the basis of examiners on the basis of examiners on the basis of examiners.	nation and/or investig	gation, in my opinio	n, death occurred a	t the time date an	d place, and due to the	cause(s) and manner stated	
	To the with com		005 0:							
	30 l		30. Name and address of person who completed cause of death ( Kemeth M. Green & MO	(Item 23a) (Type, Pr	int) (hales	St. Sc.	Je 4104	Baltmon,	mo 21204	
	Stat Registra	е	31. Dalled Hollh, 20 (2ar) Jenen 32. Regigrar's Si	dature			7- (	- /		

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 25 per doc 8929 7-31-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 20 Day 2012 John Lotz 9:30 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4018A Old Rocks Road Harford Street If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** (Month, Day, Yea Months Hours Min. 1 🔀 M 2 🗆 F Yugoslavia 213-20-9380 Director Mar. 1927 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location at with the Maryland Director notified 1 Yes 21 No Maryland Harford Street 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö pe 23a Funeral 4018A Old Rocks Road 21154 United States items ; Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1944 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status "natural", or iten edical Examiner r Black White, etc. . or 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1946 Specify: White 1 ☐ Yes 2XXNo Specify: 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Construction Worker Building Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked ည Mary Wittington Johan Lotz 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and tem 27 is r 4018 Old Rocks Road Street, Maryland 21154 Sandy Holmes / Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tonce. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State July 21, cemetery crematory er other place)
Evans Funeral Chapel
Bel Air 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State 2012 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Evans Funeral Chapel & Cremation Service-BelAir B Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final FAILURE ONGESTIVE Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ARDIDVASCULAR DISEASE TERIOSCIEROTIC Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events burial-tra resulting in death) Last Due to (or as a consequence of): physician sthe burial Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown g Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRUSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes 2 X No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? 1 Natural 5 Pending n 24 hours after נעבייי he Funeral Director: Af 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of dath (Item 23a) (Type, Print) BEL State Registrar

DHMH 17 Rev 7/2009

12-05595 Jason Ryan Leroux

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certificate of De	ath	Reg	. No.	
Physicia	ın/	Decedent's Name (First, Middle,Last)			2. Date of Death Month	Day Year	3. Time of Death 0744 hrs
Medical Exami	_	Jason Ryan Leroux  4a. Facility Name (if not institution, give street and number)	I dh Ci	ty, Town, or Location of Death	July 27, 201	4c. County of D	
		Howard County General Hospital		olumbia		Howard	
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday) If I	Under 1 Year If Under 24Hrs	_		. Birthplace (State or
Director		N/A 1ĂM 2_F	39 Yrs. M	onths Days Hours Min.	February:	27,1973 [	oreign Country Canada
	į	Usual Residence of Decedent					10d. Inside City Limits
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5-0036 ed within 72 hours after death with the Maryland itygiene. Inher than "aatural", irr items 23a or 28a-f show the Medical Examiner must be notified at once.	Director	99–145 Rice Ave		9C6R3		Canada	outing.
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	입	19a. Informant's Name/Relationship (Type, Print )	_	ress (Street and Number or F eeion Rd.W,RR1, L			
, MD and 2 sho ealth and cm 27 is	-	Lionel Leroux/Father  20a. Method of Disposition	20b. Place of Disposition			20c. Location - Cit	
Saltimore, permit. Pages I an Pepartment of He impartmat: If ite		1 Burial 2 Cremation 3 XX Removal from State	oly Cross Crem	ace) atory Augu	st 4,2012	Paris,Onta	rio, Canada
Itim it. Pa urtmen urtant	ŀ	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	22. Name	and Address of Facility Bur	ree Henss	Soitz Fune	ral Home Inc.
Deprin		Coul Myers		alls Road Baltimo	_		idi ikicijiici
Physician		23a. Part I. Enter the disease, of complications that caused the failure. List only one cause on each line.	death. Do not enter the mo	ode of dying, such as cardiac o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
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Cords, law requir has been s	plet				24a. Was an autopsy	, prio	e autopsy findings available r to completion of cause of
Recc The lav	Completed by				perform 1 Yes 2		Yes 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital:	-[]	26.Place of Death (Check			
Division of Vital Records, rate or Attending Physician: The law requirers after death.  The Director: After this certificate has been sited in by the funeral director, page 2 should the control of the	유	1 Yes 2 No Inpatient  27. Manner of Death  28a. Date of Injury	2 ✓ ER/Outpatient 3 28b. Time of Injury	DOA Other Nursir		esidence 6 0	Other:
on of anding Ph. th. r: After ti	ion	1 X Natural 5 Pending (Month, Day, Year)		1 Yes 2 No		,,	
IVISION OF Attent after death Director:	fical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, street, fac	tory, office building, etc.			r Rural Route Number, City
Division pital or Attent ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)			or Town, Sta	te)	
		29a. Certifier (Check only 1 Certifying Physician: To the best of my kn	owledge, death occurred a	t the time, date and place, and	due to the cause	s) and manner as	stated,
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examina and manner stated.	ilion and/or investigation, i				
	≊	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d, Date signed July 29, 2012	(Month, Day, Year)
NE A			(Hom 22a)	O. O. IVI. C.		July 20, 2012	
OKPLY		30. Name and address of person who completed cause of death Ling Li, MD Assistant Medical Examiner	900 W. Baltimore S	treet, Baltimore, MD 21	223		
	ate	31. Date filed (Month Day Year) 32. Registrar's S		1			
Regist		1111 31 2012 Senera	P. 19				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 29 2012 200 /Medical W 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death 4c. County of Death Examiner H050.ce 0450 8. Date of Birth (Month, Day, Yea March 14, 7. Age (In yrs. last birthday) 80 Yrs If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F Months Days Year) Hours 218-26-9738 Maryland 1932Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits I Hygiene. other than "natural", or items 23a or 28a-f show vent, I'm Medical Examiner must be rediffed at Director 1 ☐ Yes 2 XNo Maryland Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2412 Saratoga Ave. 21227 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Truck Driver Transportation Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) Nellie Jane Potter 7. Father's Name (First, Middle, Last) Carlton Leake Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Bertazon, niece 2811 Florida Ave. Baltimore, MD. 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Park 07-28-2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown his certificate has bil director, page 2 sf 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this s after death.

I Director: After this id in by the funeral di 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. If me day ddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month,

3 1 2012

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland / i		tificate of D		and w		Reg. No.	201	2 24 185
	Physicia	ń/	1. Decedent's Name (First, Middle							2. Date of Dea		y Year	3. Time of Death
	Medic	al	Joseph 4a. Facility Name (if not institution)		lajoriqu	e .	Lettre'	Lanation	of Doeth	July		2012	4:45 a <sup>M</sup>
	Examin	er	Springhouse A		no		4b. City, Town, or	esvi.			40.	County of Deat	imore
	Funeral		5. Social Security Number		e (In yrs. last birt	thday)	If Under 1 Year Months Days	If Under Hours		8. Date of Birl	:h	9. Bin	thplace (State or Foreign
	Director		019-03-5066	1 <b>X</b> M 2 □ F	89	Yrs.	IVIOITIIS Days	Hours	1	July 17			NH
	nd how at	J.	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town	n or Loc	eation			3419 17	9172		10d. Inside City Limits
	Aaryla 8a-f s tified	Director	MD B	altimore		Pi	kesville						1 🗆 Yes 2 😾 No
	the N		10e. Street and Number				10f. Zip Code				10g. Cit	izen of What Co	ountry?
	h with	Funeral	206 Slade Av				212					USA	
	r deat or iten uiner r		11. Marital Status  1 Never Married 2 Mari	12. Was Decedent I Armed Forces? ried 1 🔏 Yes 2 🗌		13. V	Vas Decedent of His FYes, specify Cubar	spanic Ori n, Mexicar	gin? (Spec n, Puerto R	ify Yes or No- lican, etc.)		<ol><li>Race - Ame Black, White</li></ol>	
21215-0036	s afte ral", c Exan	Completed by	3 ▼ Widowed 4 □ Divorced	If Vec Give	NO	1	Yes 2 X No	Specify:				Specify:	White
5-0	2 hour "natu	plet		nt's Education est grade completed)	16a	. Deced	lent's Usual Occupa	ation	t of working	a	16b. Ki	ind of Business/	Industry
121	thin 72 than the Me	om	Elementary/Secondary (0-12)	College (1-4 or 5	5+)		O NOT use retired)	amy moo		9	U	C A	
9	ed wil Hygie other ent, th	Be (	17. Father's Name (First, Middle, L	<u></u>			Co1	18. Moth	er's Name	(First, Middle,	_		
lan	l be fil lental rked c	7	Albert Edward	Lettre'	,				Adri			letier	
Maryland	should and N is ma		19a. Informant's Name/Relations	hip (Type, Print)	19b	o. Mailin	g Address (Street a	nd Numbe	er or Rural	Route Numbe	r, City or	Town, State, Zip	Code)
Σ,	nd 2 s ealth m 27		Michael Lettre	Son	_		Thorough	bred	Lane	Owin			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		cemete	ry, cren	sition (Name of natory or other place			ate		ocation - City or	
群	artmer artmer ortant injury		4 Donation 5 Other (S		Garris	$\overline{}$	Forest Ve . Name and Addres					wings M	ills,MD own Road
Ba	permi Depar Impor any ir once.		Stephen	m Jen	Kins		ine Fune		•			own, MI	
п			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cause	the death. Do r								Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition		naucal	6	9-105						Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	a con equence	of):							
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence	of):						-	
	nted d ansit	amir	Cause (Disease or injury	,								-	
	cate be executed physician and the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence	of):							
200	ate be hysici the bu	dica		d									
687	ertifica ding p		IF FEMALE:	23c. If yes, outcome	of pregnancy							20.4 D.41.4-	
XO	atteneration	ician	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 Live Birth 4 Pregnant a	2 Fetal death		Ectopic pregnancy Other (specify)	у				23d. Date of de Month	Day Year
P.O. Box	requires that the death certifichen signed by the attending should be detached for use a	Physician/M	9 Unknown	g 🗆 Unknown						1			
P.	s that gned I be de	by	Part II. Other significant condition	ons contributing to death b	out not resulting	in the u	nderlying cause giv	en in Part	I.				the cause of death?
rds	equire een si nould	eted											robably 4 d Unknown
900	≥ 55 ≤	Completed								24a. Was autop		24b. Were au prior to death?	topsy findings available completion of cause of
E R	n: The ificate or, pa		25. Was case referred to medical			_	as Pla	oce of Dea	th (Check	1 🗆 Yes			2 <b>4</b> 0
Vita	ysicia s cert direct	To Be	examiner? 1  Yes 2  No	Hospital:	ent 2 ER/Ou	utpatien	_ Othe				dence 6	R Other (Spec	ity) Assisted Living
of	ng Ph fter thi		27, Manner of Death  1 Natural 5 Pendir	28a. Date of inju	ry 28b.	Time of injury	28c. Injury work	at		8d. Describe h			,
ion	tendii Jeath. tor: Ai the fu	Certificate:	2 Accident Investi	gation not be			M 1 🗆	Yes 2 🗆					
Division of Vital Records,	after of Direct of in by	Cerl	4  Homícide determ	nined 28e. Place of Injury		arm, stre	eet, factory, office		2	8f. Location (8 City or Tow			ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical		Physician: To the best of									
	the Ho hin 24 the Fu nplete	Med	only one) 3 Certifying	Examiner: On the basis of e Nurse Practitioner: To the			death occurred at the	ne time, da			he cause	(s) and manner a	s stated.
_	Vit Cor		29b. Signature and title of certifier	1 1 4 10			29c. License		G		29d. Dat	te signed (Montl	n, Day, Year)
			30. Name and address of person	who completed cause of a	eath (Item 23a)	(Type P		6119	7		14	7:50 ,	1012
+	\		Jasun Black m	1 (76/ 1/	Charles	C	+ Cuto	410	5 70	Dason	M	0212	-04
	Stat		31. Date filed (Month, Day, Year)  JUL 3 1 201	32. Registr	ar's Signature	, Kan	,		•				
	Registra	:11	JUL 3 I ZUI	- Ceneur	10. Hara								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month J. Maloney Day James 9-05 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8026 Riker Road Elkridge Howard 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 0 1/02/1938 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Country Irginia Months Days Hours 74 578-46-2786 Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Funeral Director MD 1 Yes 2 No Howard Elkridge 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a 8026 Riker Road 21075 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 A Yes 2 No Navy
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Joseph Maloney Lillian O'Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Maloney / Son 13426 Yorktown Drive, Bowie, MD 20715 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 7/31/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility bullsin Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Diseus Medical Examiner Sequentially list conditions, if any leading to in reclaim cause. Enter Underlying Examine Disk to (or us a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physiciar by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter detached for u Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes Certificate: To Be Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 700 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 Natural injury 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 38762 7/30/12

State Registrar 31. Date filed (Month, Day,

Sharen

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Boiltimore,

We Comack

21229

Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54/1/01d Frederick 24-5+e18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 25,26 per doc g930 8-2-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Year Physician/ July24 10:53 P M Doris L. Munshi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Parkville Baltimore Quail Run Assisted Living If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday **Funeral** Days 214-30-3450 **Director** 1 □ M 2 🏋 F Yrs Aug. 23, 1933 78 Maryland Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Examiner must be notified at **Funeral Director** 1 🗆 Yes 2 😾 No MD Baltimore Perry Hall 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b any injury or other traumatic event. 9608 Amberleigh Lane 21128 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: Completed 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Thelma Litzau Ambrose Leimkuhler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Snehal Munshi husband 9608 Amberleigh Lane #K; Perry Hall, MD 21128 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 7/28/2012 Baltimore, MD 21. Signatur Fundi vice Linnses 22. Name and Address of Facility 1050 York Road a Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine BOD Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? assisted Other: 4 Nursing Home 5 Residence 6 Certificate: To 1 🗌 Yes 2 🗷 No living 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify) 24 hours after death.

Funeral Director: After this 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 5 Pending atural work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person ace Dundalle MD 21222

DHMH 17 Rev 06-2011

State

Registrar

JUL **3 1** 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 11:44a Physician/ 28 2012 Ella M. Maldeis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Parkville Baltimore 9902 Walther Blvd. 8. Date of Birth (Month, Day, Year) Feb. 17, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours 212-26-4636 Director 1 M 2X F 85 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10c. City, Town or Location notified at Director Baltimore Parkville 1 Yes X No be filed within 72 mousemental Hygiene.
Inted other than "natural", or items 23a or 28.
In event, the Medical Examiner must be no 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 21234 9902 Walther Blvd. Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify. 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Monee. own home Homemaker 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Anna Cada Edward Schafer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Lynn Ridge Court Millersville MD 21102 Nancy VanHollen 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 🕦 🗌 Cremati 1X□ Burjat 3 Removal from State 8/1/12 Baltimore MD Moreland Cemetery: 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 1 ☐ Yes 2 No this certificate 1 Yes or Attending Physician: after death. funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Hospice Other: 1 Yes/ 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer work? injury Natural 5 Pending М 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D00 2809 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt. Md. 21237 Philadelphia Rd Lonald ATTAWASIO

DHMH 17 Rev 06-2011

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State o	f Maryland / Dep	ertificate of D		, ,	201	2 24189
		Decedent's Name (First, Middle, Last)		rumouto or B		2. Date of Dear	Reg. No.	3. Time of Death
Physic Med		Peggy Ail	ene Moon			${f July}^{ ext{Month}}$	27, 2012	5:37 A M
Exam		4a. Facility Name (if not institution, give street and num		4b. City, Town, or L	Location of Death		4c. County of Death	
		1734 Bayard Avenue			dalk		Baltim	ore
Funera Directo		5. Social Security Number 6. Sex 215-60-1783	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	<ol><li>Date of Birth (Month, Day,</li></ol>		nplace (State or Foreign Intry)
	-	Usual Residence of Decedent	58 Yrs.			April 2	29,1954 No	rth Carolina
land shov d at	호	10a. State 10b. County	10c. City, Town or Le	ocation				10d. Inside City Limits
Mary 28a-f otifie	Director	MD Baltimore			Dunda	lk		1 🗆 Yes 2 🔀 No
h the	밀	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	
th wit ms 2; must	Funeral	1734 Bayard Avenue		21222			United Sta	
r dea	by Fu	Armed For	dent Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spec , Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
o36 s afte ral", c	q p	3 Widowed 4 Divorced If Yes, Given Year or Da	e	1 ☐ Yes 2X No	Specify:		Specify: W	hite
5-0	Completed	15. Decedent's Education (Specify only highest grade completed)		edent's Usual Occupat			16b. Kind of Business/I	ndustry
21 Jin 72 Je. Han "	l mo	Elementary/Secondary (0-12) College (1-	-4 or 5+) life. L	kind of work done du OO NOT use retired)		ng		
d with	Be C	12 Years 17. Father's Name (First, Middle, Last)	As	sistant Di			Adult Day	care
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	15	Lee Roy Joseph Clark			18. Mother's Name Blanche		<i>'</i>	
ould Ne mari		19a. Informant's Name/Relationship (Type, Print)	19h Mail	ing Address (Street an			City or Town, State, Zip	Cadal
M2 shauth au		Mr. Benjamin F. Moon(Hu		4 Bayard A				222
of Her		20a. Method of Disposition	20b. Place of Disp	osition (Name of matory or other place)	D	ate	20c. Location - City or	Town, State
Page Page ant: h		t Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Oak Lawn	Cemetery	8/2/2	2012	Baltimore,	Maryland
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		21. Signature of Fineral Solvice Licensee, Michael	nel L. Neiser	2. Name and Address uda-Ruck F	of Facility Funeral Ho	ome of l	Dundalk, In ryland 2122	ç.
		23a Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on ear	aused the death. Do not en					Approximate
Physician	4	Immediate Cause (Final disease or condition	Z NILAZAIA	14 1112	AUTION	.(		Interval Between Onset and Death
Medica Examine	_	resulting in death)	or as a constrouence of):	me in				
LXammo		Sequentially list conditions, b.	1897 EG V	racel	TUS			
ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence or):	TEVENT	va Pil	1100010	me Diceles	
xecut	Exa	that initiated events c. Dipe to (	or as a consequence of):	712001	02000	TULOTER	14 Disease	
Box 68760 % death certificate be executed ne attending physician and ed for use as the burial-transit	Physician/Medical	d. Hr	In PAOUD	Pre	9404		ny DISASS	
	Med	IF FEMALE:						·
Box 687 death certificathe attending properties as:	an/	23b Was decedent pregnant 23c. If yes, outc	come of pregnancy Birth 2  Fetal death 3	Ectopic pregnancy			23d. Date of deli	very
Bo deat the at hed fc	sici	1	nant at time of death 5	Other (specify)			Month	Day Year
ords, P.O. Be requires that the destached signed by the should be detached		Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause giver	n in Part I.	23e. Did toh	pacco use contribute to	the cause of death?
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ord requ	Completed	Extrames my	1			24a. Was ar		opsy findings available
<b>fital Reco</b> sician: The law is certificate has the law is director, page 2 s	Jwo	Jeson C Section				autops perforr	med? death?	ompletion of cause of
al Fian: Time: Trifficar	Be C	25. Was case referred to medical		26. Plac	ce of Death (Check	1 Yes 2	2 No 1 Yes	2 L No
f Vit	일	examiner? 1   Yes 2   No   Hospital: 1   1	npatient 2 ER/Outpatie	nt 3 DOA Other:	4 Nursing Hon	ne 5 Reside	ence 6 🗆 Other (Specif	iy)
n of ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Mont.	of injury 28b. Time o	f 28c. Injury a work?	at 2	8d. Describe ho	w injury occurred	
Sion ttendii death. stor: Al	ific	2 Accident Investigation		M 1 □ Y€	es 2 🗆 No			
or A affer affer Direction by	Certificate:	4 Homicide determined 28e. Place	of Injury - At home, farm, st ig, etc. (Specify)	reet, factory, office	2	8f. Location (Sta City or Town	reet and Number or Rura , State)	l Route Number,
Div Hospital or 24 hours afte Funeral Dir letely filled in	ical	29a. Certifier 1 Certifying Physician: To the be	est of my knowledge, death	occurred at the time,	date and place, and	d due to the cau	ise(s) and manner as sta	ted.
he Hos in 24 ha he Fun pletely	Medical	(Check 2 Medical Examiner: On the basionly one) 3 Certifying Nurse Practitioner:	s of examination and/or inves	stigation, in my opinion,	, death occurred at t	he time, date and	d place, and due to the ca	ause(s) and manner stated.
To the within 2 To the comple		29b. Signature and title of certifier		29c. License n			9d. Date signed (Month,	
		P ( the tu)		10007	14602		01/27/1	
5		39. Name and address of person who completed cause	e of death (Item 23a) (Type,	Print)	Ular 1	0 2.	BACE WE	
St	ate	31. Date files (Months Day Year)	gatrar's Signature	19KMAX	the R	a yux	water in	une
Regist		uu 31 2012 A	un S. B	ares				
DUMIL 47 D 00	2011	/	117					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / Physician/ MORRIS BARBARA Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 1832 West Lombard Street Baltimore City Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 219-40-6484 Director 1 ☐ M 2XX 76 April 12, 1936 Virginia or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct Yes 2 No Baltimore City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21223 1832 West Lombard Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 X Married 72 hours efter 2 Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) should be file I and Mental H 18. Mother's Name (First, Middle, Maiden Surname) မှ Maude Lord Lavton Morris 1 end 2 should b of Health and Mei I Item 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1839 West Lombard St., Baltimore, Maryland 21223 Ollie M. Morris, Sr./ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 e Department of I-Important: If ite any injury or ot 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Zion Cemetery July 30,2012 Lansdowne, Maryland 21. Signifure of Juneral Service Licensee 22. Name and Address of Facility ROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 allian 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician pm M disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami 4 Hospital or Attending Physician: The lew requires that the death certificate be executed

24 hours after death.

5 Funeral Director: After this certificate has been sloned by the attending. Cause (Lisease Ul finjun) attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month Month Day Pregnant at time of death ned by the a e detached f Unknown 9 Unknown P.0. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 autopsy 1 ☐ Yes 2 🗗 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 8 26. Place of Death (Check only one) 1 Yes 2 No Other: |요 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniun 5 Pending work? 1 ☐ Yes 2 ☐ No ours after death. leral Director: Aft filled in by the fur 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifie 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person v

ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Warren Rymer Matthews 28 2012 2024 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 Min. 220-38-1093 70 8/28/1941 Washygton D.C **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll 1 Yes 2 No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1066 Long Valley Road 21158 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) Fire Officer Fire Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Woodrow Wilson Matthews Joan Warren Rymer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettye Matthews-spouse 1066 Long Valley Rd., Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State South Carroll Crem 7/24/12 4 ☐ Donation 5 ☐ Other (Specify) Winfield 22. Name and Address of Facility Fletcher Funeral Home, P.A. 254 E. Main St., Westminster, MD 21157 21. Signature of Funeral Service Licensee 254 E.Main St., Westminster, MD 23a, Part Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Tortic Stinosis disease or condition Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events -tra Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the period of the signal of the si 23e. Did tobacco use contribute to the cause of death? þ Pulmonasy obstructive 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe page 2 🗌 No Yes 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☒ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending s after death.

Director: Aff 2 Accident 1 Yes 2 No Investigation М 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10031590 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225. Green Saltimore, MD State Registrar

12-05572

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Franklin Edward Morris, Jr.

2012 24192

		1- For State Registrar	Certificate of	f Death		Re	eg. No.			
Physicia		Decedent's Name (First, Middle,Last)				Date of Deat     Month		3. Time of Death		
Medical Exami		Franklin Edward Morris	, Jr.			July 26, 20		0409 hrs		
		4a. Facility Name (if not institution, give street and number)  University Hospital  4b. City, Town, or Location of Death  Baltimore								
Funeral Director	L	212-17-6792   1KM 2 F	(In yrs. last birthday) 34 Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min			Birthplace (State or Foreign Country)		
any	- 1	Usual Residence of Decedent  10a. State 10b. County 1	0c. City, Town or Locat	ion				10d. Inside City Limits		
<b>.</b> ₩	į	MD N/A	Baltimor	е				1 X Yes 2 No		
ith the Mary 23a or 28a- notified at	Director	10e. Street and Number 1634 N. Smallwood St.		10f. Zip Code 2121 (	5		0g. Citizen of Wha	at Country?		
r death w	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	ĭfY IfY	is Decedent of Hispa es, specify Cuban, I Yes 2 X No	Mexican, Puerto specify:	Rican, etc.)	Afri Afri Specify:Al	can mer.		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed t	15. Decedent's Education (Specify only highest grade comp  Elementary/Secondary (0-12)  College (1-4 or 5- 2	during m	nt's Usual Occupation ost of working life. In Stocker	OO NOT use reti		16b. Kind of Bus	iness/Industry in West		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Col	17. Father's Name (First, Middle, Last) Franklin Edward Morris	sr.			e (First, Middle, M Morri	Maiden Surname) LS			
MD 21 d 2 should lith and Mer n 27 is man	٤	19a Informant's Name/Relationship (Type, Print) LaTressa L. Morris/Wife		N. Smal			alt.,MD	21216		
MOFE Pages 1 ient of H int: If it		20a Method of Disposition  1 Burial 2 Cremation 3 Removal from Stat  4 Donation 5 Other Specify:	Balt.,							
21. Signature of Fundal Servic Licens 22. Name and Address of Facility Hari P. Clos 5126 Belair Rd, Balt., MD								.Svs,PA 06-5105		
Physician  23a. Part I. Enjer We disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line.								Between Onset and		
Examiner	1	Immediate Cause (Final disease or condition resulting in death)  a Gunshot Wounds  Due to (or as a consection)		Left Thigh				Death		
	Jer	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consection)	quence of):							
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	quence of):		_					
760, icate be executed g physician and the burial - transit	/Medical E	d.  UNPENDED AMENDED	<u> </u>							
Records, P.O. Box 68760, The law requires that the death certificate be- icate has been signed by the attending physicil page 2 should be detached for use as the burit	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 2 Fetal death 2 Fetal death 2 Month Day  1 Yes 2 No 9 Unknown  23d. Date of delivery Month Day  9 Unknown								
P.O.	Ď	1 Yes 2 V No 3 Probably								
of Vital Records, ng Physician: The law require After this certificate has been si neral director, page 2 should b	Completed	-				24a. Was autop	sy pri	ere autopsy findings available ior to completion of cause of eath?		
tal Rectian: The Certificate ector, page	悥					1 Yes	2 No 1	Yes 2 No		
cian:	Be	25. Was case referred to medical examiner? Hospital: 1 Innation			of Death (Check	only one) ng Home 5	Desidence of	04		
Physical chies	의	1 ✓ Yes 2 No	t 2 ER/Outpatient				now injury occurred	Other:		
ion of Vital I trending Physician: leath. tor: After this certifi the funeral director,	- 1	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury  29a.			es 2 🗹 No	Subject sho		<u></u>		
Division dtal or Attendi us after death.	Certification:		iry - At home, farm, stree idence	et, factory, office bui	ilding, etc.	or Town, S	tate)	or Rural Route Number, City ie, Baltimore, MD		
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exam and manner stated.								
4.24.8	Me	29b. Signature and title of certifier	•	29c. License	number			(Month, Day, Year)		
		D-~ L.		O.C.M	I.E.		July 26, 201	2		
		Name and address of person who completed cause of de     Donna M. Vincenti, MD		W. Baltimore	Street, Baltir	nore, MD 21	223			
St Regist		31. Date filed (Month, Day, Year) 32. Registrar	s Signature			_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death NASH Physician/ Month 2:55PM <u>30</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RICHE HOSPICE BALTIMORE NIA Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Year) Months Min. 1 X M 2 □ F Director 26 1943 VERSEY Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumetic event, the Medicel Evartime must be netflied at once. 10c. City. Town or Location 10d. Inside City Limits Directo BALTIMORE 1 X Yes 2 No MO 10e. Street and Number 10g. Citizen of What Country? Funeral 21218 2409 USA MARYLAND 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 ☐ Never Married 2 📈 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) INITED METHODIST Elementary/Secondary (0-12) College (1-4 or 5+) ERGY 8+ CHUNCHBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ NASH )RVILLE VAN VOORHIES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) SOUTH CARROLL CREM WINFIELD, MD 12012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility NZUMSWV FH & MON Co. Enter the dise of, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. ELDERSBURG-MO 21784 Approximate Interval Between onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ettending physician and for use as the burial-transil Due to (or as a consequence of): resulting in death) Last The law requires that the deeth certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown After this certificate has been signed by the ette funeral director, page 2 should be detached for Month Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Records, 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide Medical 29a. Certifier 1 Ocrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completed pause of death (Item 23a) (Type, Print)
That 5, III MD 6301 N Charles Street, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 5:08 P M 2012 William Norwood /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday, 83 Yrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months 215228030 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Baltimore Pikesville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 13 Wooden Court Wav USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: African-American þ 3 ☐ Widowed 4 ☑ Divorced "natural", Completed or than "natur the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Item 27 is marked other traumatic ev Pattie Boone William Norwood ೨ 19a. Informant's Name/Relationship (Type. Print) Lamont Norwood/Son 13 Wooden Court Way, Pikesville, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If Ite
any Injury or of 1 XBurial 2 □ Cremation 3 □ Removal from State Meadow Ridge Cemetery 8-4-2012 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vie Funeral Home P.A. of Paltimore Co. 21. Sign flure of Fineral Service License 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Coronary artery months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 X No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 XER Outpatient 3 □ DOA မှ 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0053928 07-27-BEQUM, MD SURAIYA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WIBELVEDERE AVENUE, BALTIMORE MD . JUL 3 1 2012 3. Registrar's Signature Registrar

State Registrar (Check

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORANAN OR

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

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5300 Brampe

2012

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29c. License number

D24761

Hagto me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of D 3. Time of Death Physician/ AUMAN MURTL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Frederick Villa Nursing Home Catonsville Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Hours (Month, Day, Year) 218-12-8561 Director 1 □ M 2 👿 F 12/22/1917 94 Maryland ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene.
If If the 72 is marked other then "naturel", or Items 23a or 28e-f show over treunestic event, the Medical Evaninar must be "utilitied as the confer treunestic event, the Medical Evaninar must be "utilitied as the confert requirements event, the Medical Evaninar must be "utilitied as the confert and the con 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 Yes 2 No MD Baltimore Arbutus 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral United States 1108 Elm Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Receptionist Dry Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Conaway Lillian Seibert 1 and 2 should b of Health and Mer Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane O'Connell / daughter 129 Klee Mill Road Sykesville, MD 21784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Atlantic Crematory 07/30/2012 Glen Burnie, MD Injury 4 Donation 5 Other (Specify) permit.
Departr
Importe
any Injt 22. Name and Address of Facility Amorose Funeral Home, Inc. 21. Signatur of Funeral 1328 Sulphur Spring Rd. Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physiclan/Medical To the Hospital or Attending Physician: The law requires that the death certificate be unithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to reledical 26. Place of Death www.k only one) Be examiner? 2 🗷 No Other: 4 Mursing Home 5 Pesidence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **№** Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#26 PER VERBAL G929 7/31/12 TRT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10: 25PM reeman 2012 July Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner Battimore Firelight Lane Apt. D Baltimore Age (In yrs. last birthday) If Under 1 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. (Month, Day, Year) Hours 1 M 2 🗆 F 83 Director 01 15 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits aţ Director Baltimore Examiner must be notified MD Baltimore 1 Yes 2 No 10f. Zip Code 9 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a 6236 21207 Hobin Hill Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 No lif Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Divorced 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Insurance Salesman 12th grade years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Violet Keynolds treeman Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) reeman permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Oliver 6236 Roban Hill Road Baltimore MD Theresa 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 2012 DWINGS MILLS, MD 12 Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services Vaud Road Kandal Jown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Tcell leukenia Physician/ disease or condition resulting in death) 12 months Medical Due to (or as a consequence of) , Examiner Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial-Physician/Medical for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy perform Hospital or Attending Physician: The 1 ☐ Yes 2 Ø No 1 Yes 2 No Division of Vital completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be RELATIVE'S examiner' 1 ☐ Yes 2 ₺ No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA မြ 4 Nursing Home 5 Re 6 **X** RESIDENCE 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 📈 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) BC7486877 July 5,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 1650 orleans Street Baltimore Mary 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Louis William O'Loughlin , 43P M a' Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c County of Death **Examiner** more quare Hospita st birthday) If Under If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 13, Year 924 Months Hours Baltimore, Maryland 88 219-16-9499 **Director** 1 XM 2 DE Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Completed by Funeral Director notified 28a-f s Parkville Baltimore Maryland 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 70 must be 2513 Hillford Drive 23a 21234 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Olough/n, Lou/sBaltimore, Maryland 21215-0036 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1XXYes 2 No
If Yes, Give
Year or Dates. Black, White, etc ō. 1 Never Married 2XX Married 1 Yes 2 XNo Specify White Specify: "natural", 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Parks Sausage Plant Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Witte ျ Edward O'Loughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2513 Hillford Drive Parkville, Maryland 21234 Katherine O'Loughlin (Spouse) 27 of Health Department of Healt Important: If item 2 any injury or other once. other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Parkwood Cametery 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State July 31, 2012 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Name and Address of Facility Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ardiopulmonary arrest disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed oronar and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 ☐ Yes 2 ☐ No Yes 2 V director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) I Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manger of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Baltimore MD. 21237

DHMH 17 Rev 06-2011

Registrar

Umar

Suleman

31. Date filed (Month, Day, Y JUL 3 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 29, Day 2012 Year 4:10 a Edith Hasenkamp Ottenritter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Lutherville 533 Wyngate Road If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Hours 218-28-4680 Director 1 M 2 XF August 10, 1929 Maryland Usual Residence of Dec or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Baltimore Lutherville 1 🗌 Yes 2 🔀 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21093 U.S.A. 533 Wyngate Road items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 K Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White "natural", Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Elizabeth O'Connell Edgar Hasenkamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traconce. 533 Wyngate Road Lutherville, Maryland 21093 husband Vernon Ottenritter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State July30,2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Fineral Service Licensee 22. Name and Address of Facilit Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Directo for as a nonsequence of attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has I autopsy performed 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one) Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie En death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of TAMES

State Registrar 32. Registr

TOWSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 24202 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Cortona 0wens 10 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HIMORE 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Country) 214-64-9581 Director 1 □ M 2 🗓 F Yrs. 93 July 30, 1918 Pennsylvania Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at **Funeral Director** 1 ☐ Yes 2X No Maryland Baltimore Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a U.S.A. 6401 N. Charles Street 21212 death v or items . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give within 72 hours after 21215-0036 1 ☐ Yes 2 🙀 No Specify 'natural", Specify: 3 Divorced 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene, is marked other tha 5+ years Teacher/Principal Education Be should be filed Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Katherine Fitzpatrick James Joseph Owens, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 permit. Page 1 and 2 6401 N. Charles Street Baltimore, Maryland 21212 Sr. Patricia Glinka, S.S.N.D. tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 8-2-12 4 Donation 5 Other (Specify) Villa Maria Cemetery Glen Arm, Maryland Signature of Funeral Service Licenses Mitchell-Wiedefeld Funeral Home, Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to mini-dialecause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Pregnant at time of death Month Year the a 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed 2 🗆 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မြ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

of person who completed

of death (Item 23a) (Type, Print)

trar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For	State of M	aryland					lental Hy	giene			
			State Registrar			Cer	tificate	of Death	7		Reg. No. 2012 21203			
п	Physicia	in/	1. Decedent's Name (First, Middle, La EDWARD O'KEEFE	ast)						2. Date of De Month	Day	Year	3. Time of Death 0430 AM	
and the same	Medic Examin		4a. Facility Name (if not institution, give	re street and number)			4b. City To	own, or Location	on of Death	JULY	28 40 Co	20;2 unty of Death	0130 74101	
	Examili	ler	UNIVERSITY OF MARYLA		CENTER	2		MORE	n or Beath		40.00	unty of Death		
	Funeral		Social Security Number     6.		e (In yrs. last		If Under 1 Months	Year If Und	der 24 Hrs.	8. Date of Birl		9. Birthp	place (State or Foreign	
	Director			1 🏿 M 2 🗆 F	67	Yrs.	IVIOITITIS .	Dayo	1	May 3, 3			achusetts	
	ind ihow at	اة ا	Usual Residence of Decedent  10a. State  10b. County		10c. City, T	own or Loc	cation			12.5			0d. Inside City Limits	
	Aaryla 8a-f s tiffed	Director	Maryland Howard		Elli.	cott C	ity						1 🗌 Yes 2 🏝 No	
	a or 2 be no		10e. Street and Number				10f. Zip C	Code			10g. Citizer	of What Cour	ntry?	
	h with	Funeral	3000 Mullineaux La	ne				21042				U.S.A.		
	r item		11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Deceder Yes, specify	nt of Hispanic ( Cuban, Mexic	Origin? (Spe can, Puerto	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
21215-0036	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 😾 Widowed 4 ☐ Divorced	1 Yes 2X If Yes, Give Year or Dates.	No	1	☐ Yes 2	X No Speci	ify:		Spe	ecify: Wh	ite	
2-0	hours natur dical	Completed	15. Decedent's	Education	1	16a. Deced	ent's Usual	Occupation			16b. Kind	of Business/Inc		
21	nin 72 ne. <b>han "</b> e Mec	omp	(Specify only highest of Elementary/Secondary (0-12)	College (1-4 or 5	5+)	life. DO	O NOT use n			ng	II C	Governm	lont.	
	ed within Hygiene. other tha	Be C	17. Father's Name (First, Middle, Last,			FTEC	tricai	Engineer					EIIL	
Maryland		To E	Edward Charles O'Ke					18. Mc	other's Name Rita	e (First, Middle, a O'Donne	Maiden Sun 11	name)		
ary	2 should be fil th and Mental 27 is marked traumatic ev		19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	a Address (S	Street and Num	nber or Rura	l Route Numbe	r. City or Toy	vn. State. Zip 0	Code)	
	and 2 st Health a tem 27 is		Jonathan O'Keefe	(Son)	1.4					ott City,				
ore	D 0 == =		20a. Method of Disposition 1   ▼ Burial 2   Cremation 3	Removal from State			sition (Name			Date	20c. Locat	ion - City or To	wn, State	
Baltimore,	Pag ant ant		4 Donation 5 Other (Spec		Good		erd Ceme		8-3-20			The state of the s	Maryland	
Bal	permit. Page Department Important: any injury o	9	21. Signature of Funeral Service Licer	lman	VOIDZ			Address of Fac in Knolls		zke Funer Columbi		es, Inc. Mand 210	45	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only			Do not ente	r the mode	of dying, such	as cardiac c	r respiratory ar	rest,		Approximate Interval Between	
~1	himiotan/	10	Immediate Cause (Final disease or condition	a. SEPSIS									Onset and Death	
1	Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):								
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequen	ce of):								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
	be executed sician and burial-transit	Ě	resulting in death) Last  Due to (or as a consequence of):											
09	the the	dical		d										
687	s that the death certifica igned by the attending p be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy	/					004	Data a Salation		
Box	atten atten I for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal de	eath 3 🗌	Ectopic pre Other (spec				230	I. Date of delive Month	Day Year	
Э.В	the de by the achec	hys	g Unknown	g 🗌 Unknown										
P.0	The law requires that the ate has been signed by the page 2 should be detach		Part II. Other significant conditions	contributing to death b	out not resulti	ng in the ui	nderlying ca	use given in Pa	art I.				ne cause of death?	
ġ,	require been sig	ted								1 🗆			pably 4 🔀 Unknown	
000	law re has bu re 2 sh	Completed by								24a. Was autop	osy	4b. Were autor prior to cor death?	osy findings available mpletion of cause of	
E E	sician: The law is certificate has the		25. Was case referred to medical					00 Di 10		1 Yes	2 X No	1 Yes	2 🗷 No	
/ita	ysician: s certific director,	To Be	examiner?  1  Yes 2 No	Hospital:	ient 2 🗌 ER	Outpation		26. Place of D		me 5 Resid	dance C .	Other (Caseifu		
of			27. Manner of Death	28a. Date of inju	iry 28	b. Time of injury		. Injury at		28d. Describe h			,	
on	ending leath.  or: After the funer	fica	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	on	y, rear)	пцигу	М	work? 1 \sum Yes 2	□No					
Division of Vital Records,	I or Atten after deat Director: I in by the	Certificate:	4 Homicide determined			, farm, stre	eet, factory, o	office		28f. Location (S City or Tow		ımber or Rural	Route Number,	
Ö	Hospital or 24 hours afte Funeral Dire etely filled in		29a. Certifier 1 X Certifying Ph	ysician: To the best of	my knowled	an dooth o	ocurred at the	no timo, data a	and place or	ad due to the or	auco(c) and n	nonnor os state	od.	
	e Hos 124 h e Fun eletely	Medical	(Check 2 L Medical Exar	niner: On the basis of e	examination ar	nd/or invest	igation, in my	opinion, death	occurred at	the time, date a	and place, and	d due to the cau	use(s) and manner stated.	
28a. Date of injury   28b. Time of injury   28c. Injury at work?   28c. Injury at work?										gned (Month, I				
			Dang diff_	P25582 July 28, 2012										
)-			. /	0. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
0	Cha		DANTE SUFFRETIM, UN 31. Date filed (Month, Day, Year)	IVERSITY OF MARY	ar's Simpature	ical CEI	NTER 2	2 SOUTH GA	LEGME S	T. BALTIN	HOPE N	1D 21201		
	Stat Registra		.111 3 1 2012 /	neur D.	ar's Signature									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month <u>A</u> <sup>M</sup> **Physician** 3:50 2012 Dorothy J. Owens July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ellicott City Howard Encore at Turf Valley Assisted Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 23, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Year) Days Hours Months 1 □ M 2 🗹 F 1915 Maryland 97 Director 220-07-2974 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I's Medical Experience must be routified at 1 ☐ Yes 2 No Director Columbia Maryland Howard the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number e filed within 72 hours after death with tall Hygiene. U.S.A. 21045 8838 Goose Landing Circle Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: ş White 3 NWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hechts Company Sales Lady 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental h pe Catherine Haas Christopher Schafer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health item 27 8838 Goose Landing Circle Columbia, Maryland 21045 Helen P. Owens (Daughter) permit. Pages 1 a
Department of He
Important: If item
arry injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State :08/01/2012 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MOO-732 McCully-Polyniak Funeral Home, P.A. 130 Fast Fort Avenue Baltimore, Maryland 21230 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** in He resulting in death) /Medical Due to (or as a consequence of): **Examiner** ronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed tiologi attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 To No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy perform 1 □Yes 2 🖼 No 1 ☐Yes 2 ☐ No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 7No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1-Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 3 ☐ Suicide 6 Could not be

P.O. Box 68760. Division of Vital Records. 24 hours after death. Funeral Director: A filled in by Hospital within 24 hor To the Fune completely fi

4 Homicide determined	building, etc. (Specify)	City or Town, State)
(Check only 2 Medical Examiner: On	To the best of my knowledge, death occurred at the time, date and plac the basis of examination and/or investigation, in my opinion, death occ manner stated.	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
29b. Signature and the of certifier	29c. License number	29d. Date signed (Month, Day, Year)
VX 1-418	07382	7/30/12

Healthway

Berlin

MO

DK.

24 31. Date filed (Month, Day,

Wolokal: e 715 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

park

Medical

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ 345A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Middle River Ivy Hall Geriatric and Rehab Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) unk **Funeral** Days Hours Director 212-42-6442 68 1 X M 2 □ F March 8, 1944 Usual Residence of Decedent or 28a-f shov 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ?? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Madical Examiner must be notified at the Maryland Director 1 🗆 Yes 2 🛣 No Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 3432 Yardley Dr. within 72 hours after death with 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) stewl worker laborer Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk ഉ t. Page 1 and 2 should be thent of Health and Mentant. If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3432 Yardley Dr; Dundalk, Maryland 21222 Linda Roth - friend Department of Health Important: If item 27 any Injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🖾 Other (Specify) in state Signature of Furneral Service Licensee 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BLANDER Immediate Cause (Final disease or condition Onset and Death Physician/ CANCER Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami signed by the attending physician and defected for use as the burial-transit Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 PNo 3 Probably 4 Unknown 1 🗌 Yes Completed After this certificate has been significate has been significated after the second of 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: At completely filled in by the fu Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24206 State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27 Jüly Charles William Pindell 2012 4:05 a.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Lutherville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 10-14-1940 Director 212-36-7579 1**X**□ M 2 □ F 71 MD parmit. Paga 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination traut be notified at any Injury or other traumatic event, the Medical Examination to approach 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 XYes 2 No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3703 Cedardale Road 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No Specify: African-American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Chef 12th Clifton T. Perkin State Hosp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brack Bunch Sarah Pindell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie I. Brown 3703 Cedardale Rd., Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Garrison Forest Veterans 8-2-2012 Owings Mills, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 23a. Park 1. Enter the disea Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Examine Due to (or as a consequence of): sata has baan signad by tha attanding physician and page 2 should be datached for usa as tha burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): PINDELL by Physician/Medical or Attanding Physician: The law raquiras that the death certificate ba P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably Completed 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed To the Hospital or Attanding Physician: Tha within 24 hours aftar death.

To the Funeral Director: Aftar this cartificata I completally filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Yes 2 💢 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖫 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of Certifie 29d. Date signed (Month, Day, Year) 201 sof person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gertrude Adeline Pirozzi 2012 6:48 PM July Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll Co. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Director 212-34-2397 1 M 2 XF 76 Jan. 19, 1936 Maryland ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 🔀 No Baltimore Edgemere 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6929 River Drive Road 21219 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🐼 No Specify: nd Mental Hygiene. marked other than "natural", Specify: 3 XWidowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Homemaker Own Home Injury or other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked o David Marshall Martha Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard V. Pirozzi, Jr. (Son) 2755 Kays Mill Road Finksburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Depertment of Important: If it eny Injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 7/30/2012 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Duda-Ruck Funeral Home of Dundalk, 21222 21. Signature of Funeral Service Licensee Gragory 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the I sease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear of idure. Hist only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and sthe burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the e 9 Unknown P.O. Part II. Other significant conditions contributing to peath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ UEX Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 1 No ☐ Yes 1 🗌 Yes 2 1 N To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) ည 1 🗌 Yes 2 🖸 № Other: 4 Nursing Home 5 Residence 6 Other (Specify) NPATTET 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one r/3 🗆 Certifying Nurse Pfactiffoner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature d title of certifier 29d. Date signed (Month, Day, Year) Name and pleted cause of death (Item 23a) (Type, Print) STMINSTER NO 2 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death Reg. No 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Physician/ N Medical 4c. County of Death City, Town, or Location of Death give street and numb 4a. Facility Name (if not institution Examiner Baltimore HOPKINS 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Maryland **Funeral** 1949 Dec. 62 218-54-0859 1 □ M 2 🏻 F Director Usual Residence of Decede 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural" or incorporate the injury or other trainments. 10b County 1X Yes 2 ☐ No Director Baltimore N/A MD 10g. Citizen of What Country? 10e, Street and Number USA 21224 by Funeral 1300 S. Ellwood Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status Specify: White 1 Yes 2 X No 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 X Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Cleaning Elementary/Secondary (0-12) House Keeper N/A 11 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Mary Louise Mende 2 James Clayton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21234 7906 Aiken Ave. Wayne Pietra/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 30, 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, MD Atlantic Crematory 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley
10 W. Padonia Road Timonium, MD 210 21. Signature of Funeral Se Flagle Michael J. 23a. Fort 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiorgan Physician disease or condition resulting in death) Due to (or as a consequente of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conseque Examiner attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Year 23b. Was decedent pregnant Month in the past 12 months? Pregnant at time of death a 🗌 Unknown the g Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by 1 🛮 Yes 2 🗆 No 3 🗀 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical Be 4 Nursing Home 5 Residence 6 Other (Specify) Other: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ၉ 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of injury Certificate: work? 1 ☐ Yes 2 ☐ No (Month, Day, Year) injury 5 Pending Natural Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check 29c License numbe 29b. Signature 2012 (Item 23a) (Type, Print) 2128 ORleans St. Baltimore an Name and address of pelso 800

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Juny 24, 2012 11:43 A M Alma Katherine Proctor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Hospice Columbia If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours  $82_{\!_{Yrs}}$ 213-26-1320 1 □ M 2 🗓 🛣 Director Maryland March 9, 1930 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 28a-f 1 Yes XX No Maryland Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 23a Funeral United States 21227 1962 Bell Ave. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XXVo
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. White 0 1 Never Married 2XXMarried Completed by 1 Yes 2XX Baltimore, Maryland 21215-0036 Specify "natural", 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) General Electric Customer Service Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearl Brown Deskin Rosier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1962 Bell Ave., Halethorpe, Maryland 21227 9a. Informant's Name/Relationship (Type, Print) Kenneth R. Proctor/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State cemetery, crematory or other place) July 31,2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature Funeral Service Licensee 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician/ FAILURE disease or condition resulting in death) Medical PULMONARY DISEASE **Examiner** OBSTRUCTIVE Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🛄 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after deat e Funeral Director: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hour To the Funer completely file (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -OWMBIA 6336 CEDAR LANE 32. Register's Signature State Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Darlene 1094 23.03.0M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** toward County Genera Howard Columb 9. Birthplace (State or Foreign Country) PA • Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🔀 F Days Min Month Day, Year) 40 207 30 5711 **Director** Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director Baltimore Maryland Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral must 4611 Warren Tree Way 21229 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Examiner Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Millard L. Ramer Yetta Heffner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo Piper / son 4611 Warren Tree Way Baltimore, Maryland 21229 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 👿 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Zion United Meth. 07/26/2012 Glen Rock, PA. 21. Sign to re of Funeral Ser 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine If any leading to inmediate cause. Enter Underlying Cause (Disease or iinjury that initiated events bunial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown for Month ed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \( \text{Yes} \) 2 \( \text{X} \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 31. Date filed (Month, Day, Year) **JUL 3 1** 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 27, 2012 Year Physician/ 8:53 р м Plank Plank Karen Joan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Country) 214-66-5259 1 M 2 K Director April 9, 1955 Maryland 57 ifiled within 72 hours area tall Hygiene.
ed other then "natural", or items 23a or 28a-f show
es eart, the Medical Evernment must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Havre de Grace 1 Yes 2 X No Harford MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21078 211 Seagull Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 A Married 1 Yes 2 X No \$ Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental be file of Health and Mental be fitem 27 is marked o ည Ε. Evelyn treumatic Thurston Hagan Eugene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 211 Seagull Dr., Havre de Grace, MD Michael A. Plank-husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1
Department of Importent: if it eny injury or o cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/2/12 Timonium, MD Dulaney Valley 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility Towson, MD 1050 York Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Examil Hospitai or Attending Physician: The lew requires that the death certificete be executed Cause (Disease or injury inding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 ettending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 A No
9 Unknown Day Month 5 Other (specify) After this certificate has been signed by the efunction of the following the detector, page 2 should be deteched a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Investigation 3 Suicide 4 Hornicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie ical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certaining Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only 🕌 e) ure and title of certifier 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) WhiD Sha heeu 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 29D & 30 PER MD G929 7/31/12 TRT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 29 2012 8:22 AM M May <u>Irian Repin</u> Medical **Examiner**  Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** unk Director 214-78-0508 Usual Residence of Deced 1 🗆 M 2 💢 F 77 Nov 19, 1934 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified 1 Yes 2 No MD Montgomery Bethesda 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8700 Jones Mills Road 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. white "natural", Completed Specify. 3 X Widowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk Decedent's Education unk 16b. Kind of Business/Industry of Health and Mental Hygrens.

If item 27 is marked other than "nr.

or other traumatic event, the Med (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $8600\ 01d\ Georgetown\ Road\ Bethesda,\ MD\ 20814$ Department of Health a Important: If item 27 is any injury or other tra Suburban Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state ne | Service dicense <sup>22. Name and Address of Facility</sup> Board 655 W. Baltimore Street MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a con a quence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical SS IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ivision of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 1 Yes 2 No \_ Yes To the Hospital o Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Irina 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 6/22/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMMIT GUPTA 8700 JONES MILL ROAD CHEVY CHASE MD 20815 istrar's Signature Date filed (Month, Day, Year) 32. Re State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Navid Richardson 70 TILLIV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice at Northwest Randallstown Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MAryland 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Feb. 4, Days Min. Hours Director 212-34-1481 1 XM 2 D F 76 Yrs. 10c. City, Town or Location 10a, State 10d. Inside City Limits Pege 1 and 2 should be filad within 72 hours efter death with the Maryland Director re!", or iteme 23e or 28e-f e Examiner must be notified Maryland Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21.228 USA 8 David Lee Court 12. Was Decedent Ever in U.S.
Armed Forces?
12. Was 2 \( \text{No.} \) No 1960If Yes, Give 1963 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify white 3 Widowed 4 Divorced 1963 Year or Dates of Health end Mantel Hygiene.
Item 27 is marked other then "netur
other treumetic avant, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Retail Pharmacy Pharmacist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Eleanor Idella Upton David Horn Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iva Mae H. Richardson/wife 8 David Lee Court Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc, 7/30/2012 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s
Department of H
Importent: If ite
eny injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland Custer 22. Name and Address of Facility Cremation Society of Maryland Inc . Signature of Funeral Service Licensee Scephanie 180 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician Liver Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hoepitel or Attanding Physicien: The law requires that the deeth certificete be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completaly filled in by the funeral director, paga 2 should be detached for use as the burial-transit Cause (Disease or mjury that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 <Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify いりかん) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending ☐ Natural Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. M shajapahlMD 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00057-465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultonore MD Walajapakserin 28.35 Smith A1 5703 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 31

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ Clarence T. Ruby Jr. 837AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLIN SQUARE HOSPITal Rosedale Baltimore 8. Date of Birth (Month, Day, Year) Sept. 28, 1954 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 217-66-5071 Months Days Min 57 1 →M 2 □ F Director MD show 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director notified Rosedale MD Baltimore 1 Yes 2X No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ıral", or items 23a oı Examiner must be Funeral 21237 USA 1 Cartwright Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ... Yes 2 ... YNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna E. Barthalow Clarence Ruby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7177 Eastbrook Avenue Baltimore MD 21224 Beverly Weiman /niece Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State Bayview Crematory 7/30/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. 21. Signature of Balto. Q Connelly Funeral Home of Essex 21221 plications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each life. 23a. Part 1/Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final Onset and Death urinary Tract Ph\_ i ian Infection disease or condition Medical resulting in death) Due to (or as a o nsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-transi metastatic mallananc and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? be detached for 5 Other (specify) Month Year Day Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural
2 Accident
3 Suicide 5  $\square$  Pending Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 55034 7-27-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLINSQUEUZ DR Balto Md 21237 31. Date filed (Month, Day, Year, JUL 31 2012 onawa 32. Registrar's Signature State

Registrar

ack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BETT RICE 11:00 PM JUL 2012 24 /Medical 4a. Facility Name (If not Institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 X Months Days 404-70-9981 63 Yrs. Director Dec. 6, 1948 Kentucky Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Heath and Mental Hygiene. ont of Heath and Mental Hygiene. ont: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at 1XXes 2 □ No Director Baltimore City Maryland 10f. Zip-Code 10e. Street and Number 10g, Citizen of What Country? 21224 United states 6212 Ellicott Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes : 1 ☐ Yes 2 X No Specify: Specify: White 2 Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +4 Healthcare Register Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ira Rice Oma Rice ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health al Important; If item 27 is any Injury or other trau once. 6212 Elliott St., Baltimore, Maryland 21224 Louis Cortner / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XXremation 3 ☐ Removal from State August 1,2012 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitAMBROSE FUNERAL HOME OF LANSDOWNE 21. Sig Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) iding physician Physician/Medical use as the IF FEMALE 23d Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 □ No the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ UVER 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 has performed? 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 3 🗆 DOA 2 FR/Outpatient မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27, Manger of Death 28b. Time of Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

al or Attending Physician: Ti s after death. I Director: After this certificate completely filled in by the funeral To the Hospital within 24 hours a To the Funeral E

State Registrar

Medical

31. Date filed (Month, Day, Year)

JUL 3 1 2012

Could not be

determined

3 Suicide

4 Homicide

(check only

29b. Signature and title of certifier

one)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

JULY 24

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month. Day, Year)

City or Town, State)

**ORIGINAL** 

1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2012 11:03 P M Thomas Calvin Rowe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** July 3 1929 1 X M 2 D F 83 Director 168-24-2667 Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The file man 23s and the darked other than "natural", or items 23s or 28s-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21046 U.S.A. 10218 Donleigh Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 🛣 Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive/Trucking Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sadie M. Lowry Ernest C. Rowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 10218 Donleigh Drive Columbia, Maryland 21046 Edith B. Rowe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Elmportant: If ite any injury or other 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Utica Cemetery 7-30-2012 Thurmont, Maryland Witzke Funeral Homes, Inc. . Signature of Egneral Price Lice 22. Name and Address of Facility 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HEART ONGESTIVE Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on) ASPIRATION NEUMONIA the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No jo Month Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEBILLITY 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 KNo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: Natural injury 5 Pending Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death Funeral Director: A Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 32. Registr State Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

F. ROWZEE EDWARD Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-05352 State of Maryland / Department of Health and Mental Hygiene Unk Unk 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1930 hrs **Medical Examiner** Edward Franklin Rowzee IV July 16, 2012 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Silver Spring 10408 Condver Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Washington, Months Days Hours Director June 24,1957 Yrs 1 X M 2\_\_\_F 55 214-52-2572 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location H 10a State 10b. County 1 Yes 2 X No or 28a-f shor Silver Spring Montgomery permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sht injury or other traumatie event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA 10408 Conover Drive Ö 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Yes specify: White f Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced 줕 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Itimore, MD 21215-0036 Federal Government 4 Accountant 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hallie Reece LeMay Edward Franklin Rowzee III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Elizabeth Rowzee/sister 863 Hamrton Circle Rochester Hills, MI 48307 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Journey Crematory 7/31/12 Woodbine, MD 4 Donation 5 Other Specify. 22 Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signatuse of Funeral Service Licensee Beverly L. Heckrotte, P.A. Clarksville, MD 2102 M01651 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death Cardiomegaly complicated by Hyperthermia Immediate Cause (Final disease Examiner or condition resulting in death) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate ause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a,27,28a-f per me g930 8-24-12 vt X UNPENDED e attending physician for use as the burial The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Month Day Year 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the ed f 23e. Did tobacco use contribute to the cause of death? signed by be detachε Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available has been a 24a Was an prior to completion of cause of autopsy death? 2 No ✓ Yes 2 No 1 Yes this certificate 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical 8 examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death subject exposed to environmental Natural Division 1 Yes 2 X No death. Director: d in by the f Pending 7:30pm 7-16-12 heat 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10408 Conover Dr. within 24 hours after To the Funeral Dire 6 Could not be Suicide residence determined Homicide Silver Spring. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 17, 2012 O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)
DDnna M. Vincenti, MD Assistant Medical Examiner
31. Date filed (Month, Day, Year)
32. Legistrar's Signature

parle

900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Carlosa 6:31PM Bunag Reyes TUK 201) Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6 len Burnie If Under 1 Year If Under 24 Hrs. nne Arundel altimorewashington Medical Center 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min 331-34-2302 Director 1 🗆 M 2 🗶 F 83 November 4, 1928 Philippines Usual Residence of Decedent at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sledical Examiner must be notified 1 Yes 2 X No Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2531 Running Wolf Trail 21113 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: Asian Completed Year or Dates Department of Health and Mental Hygiene. Importants if item 27 is marked other tran "naturany injury or other traumatic event, the Medical Egoce. 15. Decedent's Education 16a. Decedent's Usual Occupation eyes, Corlosa 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Esteban Crisobal Bunag Simeona Tuason Resurreccion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Robert John Reyes/Son 2531 Running Wolf Trail, Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State West Arundel or other place) 29 2012 July 4 ☐ Donation 5 ☐ Other (Specify) Crematory Odenton, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Estave M00672 23a. Part 1. Enter the disease, or complicatio shock, or heart failure. List only one cau s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 1 ☐ Yes 2 ☐ Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DANO မ 1 \sum Yes 1 Npatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending injury 5 Pending work? 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contributing Nurse Frantificner To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) D003274 2012 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Arci A 31. Date filed (Month, Day, Year, State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\overset{ ext{Month}}{ ext{Julv}}$ 5:58 A.M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Hammonds Lane Baltimore Anne Arundel Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. If Under 8. Date of Birth **Funeral** (Month, Day, Year) 11/24/1930 Days Hours 1 M 2 X F Min. 81 Director 218 26 4634 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified Maryland Anne Arundel Baltimore 1 Yes 2 K No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8 Wallace Avenue 21225 U.S.A. "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 2 1 Never Married 2 Married Maryland 21215-0036 Yes 2 X No Yes, 1 Yes 2 No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retai1 Rite Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Bathgate Mary Ellen Laumann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Richardson / Daughter 3643 Childress Terrace Burtonsville, Maryland 20866 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State any injury or John Cemetery 07/27/2012 Ellicott City, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Grome Zrancede 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res, iratory arrest, shock, or heart failure. List only one caus Immediate Cause (Final Onset and Deat Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 4 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: A 2 No ☐ Accident ☐ Suicide completed filled in by the Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Z Day 3:26 AM ) ~ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 200 020 Both 1 0 N/A Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Min. Hours Country Director 218 46 9443 1 🗆 M 2 🗶 F 65 Maryland 01/02/1947 28a-f show 10a. State 10h County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified Anne Arundel Glen Burnie Maryland 1 Yes 2 X No 10e. Street and Number items 23a or ner must be r ō 10f. Zip Code 10g, Citizen of What Country? Funeral 21061 U.S.A. 405 Longwood Avenue 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iten Examiner r 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. à 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bar Tender 10 American Legion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Delbert Spindle Myrtle Worley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miranda Oltman / Daughter 239 West Meadow Road Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 x Cremation 3 Removal from State 08/01/2012 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licen-22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Lis Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 0 1055 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death the Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an certificate has autopsy Hospital or Attending Physician: The I 24 hours after death.
 Funeral Director: After this certificate h perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No the Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) **JUL 3 1** 2012

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** (Month, Day, Year) Country) 1 M 2 KF 95 **Director** 217-18-0986 Virginia Jan 1, 1917 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State death with the Maryland Director 1 Yes 2 X No MD Queen Annes Queenstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö "natural", or items 23a o Funeral U.S.A. 21658 210 Harbor Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces by 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. White 3X Widowed 4 ☐ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Homemaker Own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I ige 1 and 2 should be fill of Health and Mental I: If item 27 is marked ပ Sallie Н. Breeden Rollie Leap J. other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 222 Harbor La., Queenstown, MD 21658 Janet Walczak-daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State injury or Department o Important: If any injury or St. James Cemetery 7/30/12 Monkton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 Signature of Funeral Service Licensee William G. Dau 1050 York Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year for Pregnant at time of death 5 Other (specify) Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed Yes 2 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Medical Certificate: To Be examiner? 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 5 Pending 1 Natural Investigation Accident filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State

Registrar

JUL 3 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Darshan Singh July 2012 27', 10:12 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7185 Somerton Court Hanover Anne Arundel 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) NONF **Director** 1 XM 2 🗆 F 94 Yrs Jan. 2,1918 India Usual Residence of Decede show 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Directo 28a-f Maryland Anne Arundel Hanover 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? event, the Medical Examiner must be Funeral 23a 21076 7185 Somerton Court India items ; Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Indian Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Inder Singh Rudi traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 7185 Somerton Court, Hanover, MD 21076 Chanchal Singh Dhandal / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of F Important: If ite any injury or ot once. 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place 07/31/2012 Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility MacNabb Funeral Home, 301 Frederick Road, Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 < the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis. as the t IF FEMALE ase a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for L in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a d be detached f Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Yes filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ♣ No Be 26. Place of Death (Check only one) Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, within 2

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 200, Baltimore, Maryland 21244 Asha R. Mittar, 7001 Johnnycake Rd., 31. Date filed (Month, Day, Year) **JUL 31 2012** 32. Registrar's Signature

determined

State Registrar

Medical

29a. Certifier

(Check only one)

back

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John Tyler Shaffer 30° 2012° Physician/ 1:33 A. M July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death TOWSON Examiner Baltimore County Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Nov. 02, 1936 Baynesville,MD. 75 213-34-1208 1 1 M 2 □ F Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumetic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director Baltimore County Timonium 1 Tes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 55 Greenmeadow Drive 21093 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Secondary (0-12) Meat Butcher Butcher Shop Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Emily Miller Ralph Gary Shaffer 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Timonium, Maryland Dorothy Jo (nee Mershon)Shaffer 55 Greenmeadow Drive: 20c. Location - City or Town, State (Baltimore County) 20a. Method of Disposition 20b. Place of Disposition (Name of Date pulancy Valley Memorial Thursday, August 02,2012 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature of Funeral Spyvice Licenses Jeffrey L. Cair, Sr. O.S. 22 Name and Address of Facility ives Funeral and Cremation Center, P.A. 21093-2215 Lic.#M00677 Timonium, Maryland 2325 York Road or complications that caused the death. Do not enter the mode of dying, such as lardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 1 naum Medical Examiner Sequentially list conditions, it amy leading immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Exami that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time = 1 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 🗌 No 6 X Other (Specify) HOS ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 Yes 2 No tal 16/5015 6300 A Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, building, etc. (Specify) 28f. Location (Street and Number or Rural Route Numbers 7. City or Town, State) 5701 N.Chenles 57. Towson, NS 21204 determined 39.1c Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29c. License number 29d. Date signed (Month, Day, Year) M-D F851F00Q 7-30-12 leted cause of death (Item 23a) (Type, Print) Shaheen, 6701 N. Charles St. & 4105, Baltimore, MD 21204

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>□</sup>2012 1130A VERNON July 30, MILAN SMITH, M.D. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 575 Highbank Road Anne Arundel County Severna Park If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Yea Country) 215-09-3924 **Director** 1 X M 2 □ F Aug 21, 1921 90 Florida Usual Residence of Decedent or 28a-f show notified at 10a. State death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Severna Park Maryland Anne Arundel Co 1 Yes 2 X No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 575 Highbank Road 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?
1 X Yes 2 □ No or Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after WWII r than "natural", of 1 ☐ Yes 2 X No Specify White If Yes. Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I 5+ Gastroenterologist Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank H. Smith Brouilette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204 C. David Heisler (Pers. Rep) 102 W. Pennsylvania Avenue, Suite 200, Towson, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Metro Crematory, Inc Aug 1, 2012 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signath of Fundal Service Districtions

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) mentia Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed se (Disease or injury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the at ending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year g 🗌 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2, No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed this certificate Yes 2 Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) examiner? 1 Yes 2 No ြုင Other: Nursing Home 5 Aresidence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner & Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director, After 1 Natural 5 Pending work Accident 1 Tes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29c. License number

Registrar DHMH 17 Rev 06-2011 8028 Ritchie Highway, Suite 108, Pasadena, Maryland 21122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD,

Jeffrey Atkinson

			Please	Type or Prir					_		_				
		For State Registrer		State of Ma	aryland /		artment of h rtificate of			Reg. No.	-016	24225			
Physicia	an	Decedent's Nam		2. Date of D	Day		3. Time of Death								
/Medic Examin		Ann Dawson Samuers 24 2012													
Funeral Director	eı	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 18. Date of Birth (Month, Day, Year) 9. Birth (Month, Day, Year)									thplace (State or Foreig ountry) rginia				
pu *		Usual Residence of 10a, State	f Decedent 10b. County		10c. City, T	own or Lo	ocation					10d. Inside City Limits			
Maryla f shor	ŏ	MD			Balti						1 MYes 2 □ No				
n 28e	Director	10e. Street and Nu	mber		1		10f. Zip Code			10g. Citi	izen of What C	ountry?			
23a c	alD	6911 Par	k Heights	Avenue			21215			USA					
is a rank 2 should be into within 72 hours arier beath with the manyand attended and a ranked other then "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examination to the conflict at	by Funeral	11. Marital Status  1 □ Never Mari 3 □ Widowed	ried 2☐ Married 4∑Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ② If If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ② No	lo-	o- 14. Race - American India Black, White, etc. Specify: Black						
nature ligal E		/Sne	15. Decedent's Ed cify only highest grad		1	6a. Dece	dent's Usual Occup	pation	orkina	16b. Ki	16b. Kind of Business/Industry				
Je.	Completed	Elementary/Seco			College (1-4or 5+) life. DO NOT use retired)										
Hygiel thar ti nt, th		17 Father's Name	(First, Middle, Last)	5		Kegi	stered Nu		me (First, Middle		Health				
o per	) Be		T. Dawson	. Ir.					eth Fow						
27 is mark r traumati	우	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 46 Star Flower Drive, Bluffton, SC 2990													
item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. L 20c. L										Town, State			
ant: If			☐ Cremation 3 ☐ 5 ☐ Other (Specify			•	Cemeter		1-12	Cha	rlottes	ville, VA			
Important: If item 2 any injury or other QDCe.		21. Signatur of Fi	uneral Service Lieens	xo nd	Qe	100	2. Name and Addre 5517 Vine		-			l Service 2310			
/sician ledical		23a. Part1. Enter in shock, or head immediate Cause disease or condition resulting in death)	art failure. List only o (Final on	olications that caused one cause on each lin	the death. D	o not en	ter the mode of dyin	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death			
nysicien and he burial-transit	Ical Examiner	Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate causa. Extra Underlying Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):    Due to (or as a consequence of):													
should be detached for use as the buriar	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown									23d. Date of de Month	Nivery Day Year			
d be deta	Ď	Part II. Other signi	ficent conditions co	ontributing to death be	ut not resultin	g in the u	nderlying cause giv	ven in Part I.				o the cause of death?			
oage 2 shou	Completed	NO	rmal p	ressure	hydi	10 CE	phalus			opsy form <u>ed</u> ?	prior to completion of cause of death?				
ctor, 1	Bec	25. Was case reference							ath (Check only	one)					
ufter t	on: To	1 ☐ Yes 2 ☐  27. Manner of Dear  1 ☐ Natural  2 ☐ Accident	NAO	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day	ry 281	Outpatier b. Time o Injury	f 28c. Inju		Home 5 Res			ecify)			
I Director	Certificati	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubul	ury - At home c. (Specify)	, farm, st	reet, factory, office			(Street an own, State		lural Route Number,			
To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier (Check only one)		ysician: To the best of tiner: On the basis of and manner sta	examination										
To tr comp	Me	29b. Signature and	title of certifier	\ . i -			29c. Licens	se number			te signed (Mon				
		_ ► lax	mi H. I	yer, MD	)		RES	-000		Tul	424,	2012			
		Laxin	i Ho Dye	completed cause of d	Sur	ai	tospital	l of ba	It mio	le:	0				
Sta Registra		31. Date filed (Mor	L 3 1 2012	/32. Registra	ar's Signature	par	Val.	V							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death <sup>Day</sup>2012 July Physician/ Jessie Smith 26. 9:50 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 16311 Accolawn Road Accokeek Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 168-12-6891 Director 1 □ M 2 🔀 F 92 Yrs. July 4, 1920 Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important; If item 27 is marked of other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits Director Accokeek MD Prince George's 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20607 USA 16311 Accolawn Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Clerk Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martha S. Miller Moses Labar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16311 Accolawn Road, Accokeek, MD 20607 Debra Unger - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 7-27-12 Alexandria, VA Donation 5 Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service Sign ture of Fu 5517 Vine Street, Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 86 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month 1 Yes 2 No Pregnant at time of death Day Year Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 1 No death? this certificate I ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 X No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Natural 2 Accident work? 1 🔲 Yes 5 Pending Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

oad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOVIS

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 293y Ann 20°° 10:30am Marjorie Small Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 13037 Marquette Lane Bowie Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X**□ F (M804) <del>[7</del>7/1934 New Jersey Director 217-66-0744 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 □ No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 13037 Marquette Lane 20715 USA be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", Specify: Completed 3 - Widowed 4 - Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical any injury or other traumatic 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Photographer 12 Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George W. Guensch Evelyn McLearn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Small / Daughter 13037 Marquette Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 7/31/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility once. Borota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) Month 5 Other (specify) signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician; The law is within 24 hours after death.

To the Funeral Director, After this certificate has be completed filled in by the funeral director, page 2 s. autopsy performed Yes 2 🗹 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 🔲 Yes မူ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nu e Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 28 2012 Luis Santiago Salazar 9:15 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6308 23rd Avenue Prince George's Hyattsville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Countre Peru 1**X** M 2 □ F Min (MOTH/23/14930 578-76-9155 62 Director Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Yes 2 No MD Prince George's Hyattsvile 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6308 23rd Avenue 20782 **USA** death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 □ No Specify: Peruvian If Yes, Give . Year or Dates 3 Widowed 4X Divorced Specify. Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) **HVAC** Engineer **WMATA** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fis marked of ပ Mariano Salazar Delia Calderon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i Leticia S. Salazar / Daughter 1848 Columbia Road NW #32, Washington, DC 20009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 7/31/2012 Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, Baltimore, MD 21203 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final fh sician/ disease or condition resulting in death) Medical Due to (or as a cons quence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: use a yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Day Pregnant at time of death Other (specify) been signed by the s should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy funeral director, page 2 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗹 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manper of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury ✓ Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature anal 29d. Date signed (Month, Day, Year) 07-30-2012 30. Name and addre on who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 26, homas 2012 6=12PMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O6/07/1950 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 214-58-5723 Yrs 62 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director MD **Baltimore** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 3117 E. Baltimore Street 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ 3 Widowed 4 NDivorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Cab Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Scharf ည Lucille Bray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 Is any Injury or other tract Melissa Scharf / Niece 3117 E. Baltimore Street, Baltimore, MD 21224 20a. Method of Disposition
1 □ Burial 2 🎖 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 7/31/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall U 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OSpirator disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner neumonio Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of; The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 2 🗌 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 No 1 ☐ Yes certificate 2 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ eral Director: After this if filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation (Month, Day 1 🗌 Yes 2 🗍 No 3 🗌 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 4 Homicide City or Town, State) within 24 hours a To the Funeral C 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 11595 4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 28 201 Zear Frederick M. Smith Jr. 10:39aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 325 Dark Head Road Middle River If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Oct. 19, 1955 218-66-4385 1 XM 2 □ F 56 Director PA 23a or 28a-f show filed within 72 hours after death with the Maryland al Hygiene. 29 of ther than "natural", or items 23a or 28a-f show State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Middle River MD Baltimore 1 ☐ Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 325 Dark Head Road 21220 USA "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify 3 Widowed 4 Divorced Completed Year or Dates Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working HAIWW Contrators Elementary/Secondary (0-12) College (1-4 or 5+) the Operator Engineer 12th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick M. Smith Sr. Janice M. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget Smith /daughter 3625 Arkansas Drive Columbus GA 31907 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 2 Cremation 3 Removal from State 1 🗆 Burial Bayview Crematory 7/30/12 Baltimore MD 4 Donatio Other (Specify) 22. Name and Address of Facility 21. Sign neral Servi 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 18 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Title to for as a nonsequence on cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 2 No the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after deau..

To the Funeral Director: After this ( 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending injury Accident Suicide Investigation Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

Registrar
DHMH 17 Rev 06-2011

CA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Month 20° 20°1′2 3:30 A M Margaret Annadale Smyth Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St Agnes Hospital Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Director 218-18-3364 87 1 □ M 2 XX Dec. 5, 1924 Maryland 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2XXVo Maryland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21227 3300 Benson Ave. Apt#323 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 A. No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 XXVidowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Homemaker Own Home N/A other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Kick Claggett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8731 Lasalle Ct., Ellicott City, Maryland 21043 Joyce Phillips / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XX Burial 2 Cremation 3 Removal from State Department o Important; If any injury or once, ō Meadowridge Mem. Prk. July 24,2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Juneral Service Licensee 22. Name and Address of AMBROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 Approximate Interval Between Oncet and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death
Unknown signed by the at the detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 2 No \_ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To funeral ( 28a. Date of injury (Month, Day, Year) Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending work? 2 No Accident Suicide Investigation Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ow 1 who completed cause of death (Item 23a) Type, Print) or char 3 1 2012 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23, 2012 July Seifu Patricia E. Medical 0620 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 143-30-7661 Director 1 □ M 2 🕱 F Feb 19, 1940 New Jersey 72 Usual Residence of Dece or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🄀 No Silver Spring MD Montgomery 10e. Street and Number ò 10g. Citizen of What Country? pe 23a Funeral must United States 1401 Blair Mill Road #1819 20910 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. "natural", or item edical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Black Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Education Program Coordinator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Valeria Stafford Phillip Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, MD 20910 1401 Blair Mill Rd. #1819 Tadesse Seifu / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Journey Crematory 7/30/12 4 Donation 5 Other (Specify) Woodbine, Maryland Flinal Signature of Funeral Service Consee Coing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard allure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ cman disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last tim uly Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Style Rend 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 🗌 Yes 2 🗌 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗌 No 4 hours after death Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Until included Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely only one) rse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 100057574

State Registrar 30. Name and address of p

31. Date filed (Month, Day, Year)

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Research Bbulevard Svite 330 Rockville MD 2050

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar			Certific	cate of	Death			F	Reg. No.				
	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. 1											3. Time of Death		
rr~dic	al Exami		Roy Shinaberr	y, Jr.			July 26, 2		Teal		1630 hrs					
			4a. Facility Name (if not institution St. Agnes Hospital	on, give street ar	nd number)	-	41	o. City, Town, or I Baltimore	Location o		4c.	County of	Death			
	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last bi	rthday)	If Under 1 Year	If Under	r 24Hrs.	8. Date of B	irth(MM/I	DD/YYYYDD	9. Birth	place (State or	
	Director		224-33-7592	XX M 2	F		37 <sub>Yrs.</sub>	Months Days	Hours	Min.	April	25,	1975	Foreign Cour	nt <b>Gali</b> fornia	
	<b>A</b>		Usual Residence of Decedent		14	On Oity Tave	Iti-								10d. Inside City Limits	
	ath with the Maryland items 23a or 28a-f show any ist be notified at once.	_	10a. State 10b. County 10c. City, Town or Location  Maryland Baltimore Lansdowne												1 Yes XX No	
	arylar  Sa-f s	윉	10e. Street and Number					10f. Zip Code			10g. Citizen of What Country?					
	he Mi t or 2		3217 Bero Road 21227									Unit	ed St	ate	s	
	with t	펻	11. Marital Status	12. Was	Decedent E	ver in U.S.		Decedent of His			oify Yes or N		14. Race -	America	an Indian, Black,	
	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene and "natural", or items 23a or 28a-f sho ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral Directo		1 1	A.A			s, specify Cuban,		Puerto Ri	can, etc.)	White, etc White				
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212	Meni Mari	일	19a. Informant's Name/Relation			19	9b. Mailing	Address (Street				ımber, Ci	ty or Town,	State, 2	Zip Code)	
M OM	2 sho h and 27 is		Shawna A. Thoma	s / Fia	ncee'	Ĭ	3217	Bero Roa	id, La	ansdo	wne,M	ary1	and 2	122	7	
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			State Registrar			Cer	tificate of E		Reg. No. 2012 242.						
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Sio	or Attending after death. Director: After I in by the fune	ij.	2 Accident Investigat 3 Suicide 6 Could not	t be	ırv - At hom	ne. farm stree	M 1 ⊔ Y	es 2 No	28f Location /S	treet and Number	or Pural I	Pouto Number			
Division of Vital Records,	al or A		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location								n (Street and Number or Rural Route Number, Town, State)				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death within 24 hours atter death.  Whith a funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transical director.	Medical	29a. Certifier 1 Certifying Pl	hysician: To the best of	my knowle	dge, death o	curred at the time,	date and place,	and due to the ca	use(s) and manne	er as stated	d			
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1 perphys, G930, 8/17/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle Last)
1 Tima Joan Sitaram
1 Trma Jean Sitaram 2. Date of Death 3. Time of Death Month Physician/ Day July 2012 3:05 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Wheaton Manor Care If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In yrs. last birthday) Days Hours 7/24/1932 580-02-0856 Director 1 □ M 2 👺 F Trinidad 80 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f Christiansted, St. Croix 1 Yes 2 XXVo VT 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò must be 23a Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. 00823 USA 369 Estate Humbus items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 6 þ 1 Never Married 2XXMarried 1 Yes 2 XNo
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 Black 1 Yes 2XXNo Specify Specify "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working the M life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Finance 12 Banking Clerk 7 is marked other traumatic event, tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward St. George Margaret Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 369 Estate Humbug, PO Box 6556 Christiansted, VI item 27 i Cathy-Mae Sitaram, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, <del>=</del> 5 Department of Important: If any injury or once. Chesapeake Crematory 7/28/2012 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funery Service y M00382 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition and disease or condition and death)

a. The part of the disease or condition and death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease)

a. The part of the disease or condition and the death of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 9 Unknown ò Month Day Year be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes 2 No Yes 2 25. Was case referred to medical funeral director. To Be 26. Place of Death (Check only one) examiner? Other: 1 Yes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of Certificate: 1 Natural 2 Accider 5 Pending work within 24 hours after death.

To the Funeral Director: Afcompletely filled in by the fu 2 No 1 Yes Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check the only one Certifying Nurse Practitioner: To the est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign ure and title 29d. Date sign 1810 milip 30. Name a Prince 1BV

State Registrar 31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician Medical Examine	1	<ol> <li>Decedent's Name (First, M</li> </ol>	ddle,Last) tthew	Shields	,		-			Date of Death Month	Day	Year	3. Time of Death 0902 hrs		
Miculcal Examine		4a. Facility Name (if not instit				41	o. City, Town,	or Location o		luly 23, 20		ounty of Death			
	Ļ	2435 Duvall Road					Woodbine			Howard					
Funeral Director	L	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 50 Yrs.    Funder 1 Year   Funder 24Hrs.													
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the Marylanc a or 28a-f sh tifted at one	3	14364 Saguaro Pl	ace				10f. Zip Code 20121			100	U.S.A.				
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ratt of Health and Mental Hygiene.  Ant: If item 27 is marked other than "natural", or items 23a or 28a-7 sho or other traumatic event, the Medical Examiner must be notified at once.  To Ro Commissed by Einneral Director	I CI O	11. Marital Status	Married	12. Was Decedent Armed Forces?			Decedent of I s, specify Cub				14	Race - Americ White, etc.	can Indian, Black,		
s after d			Divorced If	Yes, Give Year or Dates:	es, Give Year Dates: ighest grade completed) 16a. Deceder			Yes 2 No specify:				ecify: Whit			
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan		12		4		Self		Maste			ster Carpenter				
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than sumatic event, the Medica. TO Be Comple		17. Father's Name (First, Mid Frank Shield						18.Mother		rst, Middle, Ma Fot	aiden Su ten	rname)			
ould be fine out of the count of the count,		Frank Shield 19a. Informant's Name/Relation		e, Print )		19b. Mailing	Address (Str					or Town, State,	Zip Code)		
y, MD 21215-0036 and 2 should be filed within 72 hours after leath and Mental Hygiene. ten 27 is marked other than "natural", traumatic event, the Medical Examiner. To Be Commissed by		Frances J. Shiel	ds (Mot	ther)	20h P	8559 Balace of Disposit				ryland 2		cation - City or	Town State		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other th injury or other traumatic event, the Med		1 Burial 2 Crema		Removal from St	ate cr	rematory or other	er place)			5/2012   Glen Burnie, Maryl					
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Vital Records, Prysician: The law requires the system of the seen sign director, page 2 should be entered to the Completed to the Completed to the seen sign of the Completed to the seen sign of										24a. Was ar autopsy perform	red?		opsy findings available ompletion of cause of		
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f Vital Re Physician: The er this certificate ral director, page	Ď	examiner? 1 ✓ Yes 2 No		spital: 1 Inpatie	ent 2 🔲 I	ER/Outpatient		-			esidence	e 6 🗸 Other:	Scene		
Division of Vital Records, P.O. pital or attending Physician: The law requires that thours after death.  Bread Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.		27. Manner of Death  1 Natural 5 P	ending	28a. Date of Inju (Month, Day,Y FOUND: Jul 23, 2012	ear)	28b. Time of In FOUND: 0856 hrs	ury 28c. Ir	ijury at Work Yes 2 ✔	Isu	d. Describe ho bject shot		occurred			
Division or spital or Attending tours after death.  In a Director: After filled in by the fune for the formal Director.		3 Suicide 6 Could not be determined (Specify) A poster and							c. 286 243	f. Location (Sta or Town, Sta 35 Duvall Ro	reet and ite) ad, Wo	Number or Run odbine, MD	ral Route Number, City		
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To witi		29b. Signature and title of cer		nd manner stated.				nse number				te signed (Mor	nth, Day, Year)		
	4	tauch	- KE	ller			0.0	C.M.E.			July 2	4, 2012			
0	30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									3					
Stat	~	31. Date filed (Month, Day, Ye	ar)	32. Registra	,										
Registra	П	<u>JUL 3 1 2012</u>	Bre	S.	Mar	Ked									

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OCME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY Physician/ 26 2012 01:10A M SNYDER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COLUMBIA HARMONY HALL ASSISTED LIVING 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. Date of Birth Social Security Number Country) PA **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 127 Pay 1921 90 Yrs Director 188-16-5325 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 💢 No MD HOWARD COLUMBIA 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 6336 CEDAR LANE #328A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural" Completed 3 X Widowed 4 ☐ Divorced WHITE the Medical Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ **ABRAHAM** BERNSTEIN MINNIE SHERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4640 LEARNED SAGE, ELLICOTT CITY 1MD 21042 AMY ADAMS / DAUGHTER 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State Date Department of F Important: If ite any injury or oth cemetery, crematory or other place, 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 07/29/2012 4 Donation 5 Other (Specify) PHILADELPHIA, PA Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? ó Month Day Year 2 🗌 No should be detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed' 2 🗌 No 1 ☐ Yes 2 🗓 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be 4 Nursing Home 5 Residence 6 Norther (Specific) Hospital: Other: 2 🛛 No 1 🔲 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work 1 X Natural 5 Pending 1 Yes 2 No after death. Accident Investigation the 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To within 2 To the he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who co

JUL 3 1 2012

ANDREW LAZRIS

6334

leted cause of death (Item 23a) (Type, Print)

LANE,

2. Registrar's Signature

CEDAR

( PYCP

#103, COLUMBIA, MD 21044

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ) Day 26 Year 2 Physician/ 0073 M Walter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Universityat Waryland Medical Center Bultimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 212-42-0713 03/20/1943 1 X M 2 🗆 F Maryland Director 69 Usual Residence of Deced 28a-f shov 10h Count 10c. City, Town or Location
Forest Hill of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits with the Maryland Director Maryland Harford County 1 ☐ Yes 2 🎽 No 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 21050 Funeral 2004 Galway Drive Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Surveyor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Helen Marie Russell Walter Phillip Tydings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 2004 Calway Drive, Forest Hill, Maryland 21050 it of Health a Katherine Marian Tydings (Wife) 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Forest Hill, Maryland 07/31/2012 Department of Important; If it any injury or conce. Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ars Funeral Charel & Cremation Services - Bel Air Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a consequence of) **Examiner** Yweeks Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease Or injury that initiated events Due to (or as a consequence of) burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be emitin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year signed by the at I be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Greene St

Darks

32. Registrar's Signature

7/26/12.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of I lonth Physician/ URNER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Seasons Hospice Randallstown If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Funeral Days Hours. Director 1 🕅 M 2 🗆 F 216-36-3823 Usual Residence of 2-14-1940 72 MD th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore Reisterstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 631 St. Georges Station Road 21136 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. ۾ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: African-American 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Supervisor BARC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Herbert Bass Catherine Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Turner/Wife 631 St. Georges Station Road, Reisterstown, MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lukes United Methd. Ch : 8-2-2012 Reisterstown, MD 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service License 9200 Liberty Rd. Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Throm bosig Physician/ Due to (or as a consequence of) Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day been signed by the s should be detached g | Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 🗆 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of

331

State Registrar 31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23)

6934 Au

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 30 30 2012 4:50 Donald Leroy Torney Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 508 Skyview Drive Calvert Lusby Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year Birthpia. Country DC **Funeral** 1**X** M 2 □ F Months Days Hours (Month Day 1482) 219-46-5119 65 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 □ No Calvert MD Lusby 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō ms 23a or must be n Funeral 508 Skyview Drive 20657 **USA** ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1. Yes 2 □ No Navy If Yes, Give 11 Marital Status 14. Race - American Indian Black, White, etc Page 1 and 2 should be filed within 72 hours after oment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examin Completed by 1 Never Married 2 Married 2 □ No Navy Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Electrician Service 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Evelyn Sansbury John Torney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3080 Karen Drive, Chesapeake Beach, MD 20732 Tarvn Millsaps / Daughter Department of Health Important: If item 27 any injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 8/1/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CANCER Physician/ HEPATOCELLULAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending use yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Day Pregnant at time of death Year the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by MYPERTENSION 1 Tes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has Yes 2 X No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🔲 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 🙉 tifier 29d. Date signed (Month, Day, Year) D0067788 7.31.2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H.G TRUEMAN RD, SUITE 2100, SOLOMONS, MD-20688 14090 RAO. KODALI

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $J_{uly}^{Month}$ 2012 0425 A Berklev Tyler Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Ritchey Hospice Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days (Month, Day, Yea 06-06-46 Hours Min 219-40-8838 Director 66 1 🛛 M 2 🗆 F MD 27 is marked other then "naturel", or Items 23a or 28e-f shov treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21207 3921 Maine Avenue Apt. #A-2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. African Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry de completed) (Specify only highest gi permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then 'eny injury or other treumetic event, the Me 2010. Elementary/Secondary (0-12) College (1-4 or 5+) City of Baltimore 12th Grade 2vrs. Housing Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tyler Robert Johns Iantha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 N. Eden Street Baltimore, Maryland 21205 Christine Holly-Sister-in-law Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
King Mem. Park 1 X Burial 2 Cremation 3 Removal from State 10 08-03-12 Randallstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Dicenses Wylie Funeral Home P.A. Gilmor Street Baltimore, Maryland 21217 638 N. 22a. Part 1. Enter the disease, or cor shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nly one cause on each line. Onset and Death Immediate Cause (Final ( >nc Physician/ Krost disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Funerei Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Hospital or Attending Physicien: The lew requires thet the death certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68766 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice Medical Certificate: 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours a To the Funerel C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 29c. License number 60 3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/  $J_{\rm uly}^{Month}$  28 6am <sup>™</sup> <u> Thomas William Willetts</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1321 Mount Carmel Road Parkton If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** Months Davs Hours **Director** 214-16-2202 89 1 XM 2 □ F Jan, 2, 1923 Maryland Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Maryland Baltimore Parkton 10e. Street and Number 10f. Zip Code ritems 23a or ner must be n 10g. Citizen of What Country? Funeral 21120 USA 1321 Mount Carmel Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian "natural", or iter edical Examiner ed Forces? Yes 2 No 1941-Armed Force:
1 X Yes 2
If Yes, Give
Year or Dates Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify White 1945 Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Dentist Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) Thomas W. Willetts Nina Cottington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Page 1 and 2 sment of Health stant: If item 27 i 14213 Quail Creek Way#312 Sparks, Maryland 21152 Brian D. Willetts/son Important: If ite any injury or oth 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory,Inc. | 07/30/2012 | Baltimore,Maryland 4 Donation 5 Other (Specify) re of Funeral Service licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final - Ptwwician/ disease or condition resulting in death) JEANS Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying bras a conseque attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death signed by the af Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? s after death. Certificate: 28d. Describe how injury occurred Matural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide determined 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a H0056488 2019 cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Robin MotterMast,

3 1 2012

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

9 Schilling Road, Suite 102, Hunt Valley, MD 21031

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Day 2012 Physician/ Elizabeth White Month 70 P Medical J414 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Seasons Hopsice 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours 10 12 1928 ear) VA <u>216-34-7737</u> Director 1 □ M 2 🕮 F 83 I Hygiene. other than "natural", or items 23a or 28e-f shov vent, the Merical Examiner must be notified at 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 211.33 LISA 4004 Carthage Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyAfrican-American Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Physical Therapist Dr. Leroy Young Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is man ed out eny injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Tumer Luetta Pope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4004 Carthage Road, Randallstown, MD 211.33 Cynthia Noel/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u> Carrison Forest Veterans :</u> 8-1-2012 Owings Mills MD o Freral Service Licensee 21. Signatur 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Atheroscientic Cardiovascular Priysician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the ettending physicien and thed for use as the burial-transi or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 menths?
1 Yes 2 No Pregnant at time of death Month 1 Yes 2 E cate has been signed by the cage 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2: autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 1 No Other: 4 | Nursing Home 5 | Residence 6 | Other Specify ent hapice ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NSROJAPUNU MO 7/26/12 00057415 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSRayaya VSLMD

2835 Sm. In AV 2835 Smith N 5703 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 31

Registrar

## Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Leo Winfield, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death
BOLTMORE **Examiner** lowsori If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. (Month, Day, Year) 220-18-3996 Director 1 X M 2 □ F 85 Sept. 24, 1926 Maryland Usual Residence of Deceden 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 28a-f MD Baltimore Lutherville 1 ☐ Yes 2X No 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12040 Tralee Road #301 21093 USA or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) if Health and Mental Hygiene. item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner I 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 43 -46 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/ABuilding Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Leo Winfield, Sr. Margaret Bidenbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Winfield/Wife 12040 Tralee Road, 301 Lutherville, MD 21093 20a Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot July 27. 20c. Location - City or Town, State 1  $\square$  Burial 2  $\boxtimes$  Cremation 3  $\square$  Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2012 Glen Burnie, MD Signature of Funeral Se 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael J. Flag1e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death ndifferent Physician/ disease or condition resulting in death) Medical **Examiner** rcinoma Sequentially list conditions Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural injury 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) of death (Item 23a) (Type, Print) 7601051eR Towson Md 21204. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Peter Bruce Walker 7:55 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 543 Beach Drive Annapolis Anne Arundel Social Security Numbe Sex 1X M 2 D F Age (In vrs. last hirthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** Countre D.C. Months Days Hours (M976/23/1946 216-50-5655 65 Director Usual Residence of Decedent should be filed within 72 nouse and and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show it is marked other than "hatural", or items 23a or 28a-f show if is event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Tyes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 543 Beach Drive 21403 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Engineer Chemical 12 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Roy Walker permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. other traumatic Lois Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Elizabeth Walker / Wife 543 Beach Drive, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 7/31/2012 Beltsville, MD Signature of Funeral Service Lip 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ bronchoyenu disease or condition Medical resulting in death) Due to (or as a consequent e of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death signed by the a 2 No 9 Unknown Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No æ 26. Place of Death (Check only one) Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural iniury 5 Pending 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: Totale best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P 31. Date filed (Mo Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1 Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Walker Mildred . Ju1v30 2012 5:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Heritage Nursing Home Baltimore Dunda1k 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 218-26-9081 Director 1 □ M 2 🗓 F April 24,1929 Maryland 83 Usual Residence of Deceden 28a-f show at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD 1 Yes 2 X No Edgemere Baltimore or. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2117 Maple Road United States or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: 3 X Widowed 4 Divorced Completed oe filed wn. \*vtal Hygiene \*ther than "natu. \*e Medical Ex White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) traumatic event, the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o ည Mildred D. O'Malley William B. Bateman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2117 Maple Road Dundalk, Maryland 21222 item 27 Kimberly A. Walker (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Legartment of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 8/1/2012 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. Towson, Maryland 21. Signature of Funeral Service Licensee Justin A. Jones Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 23d. Part 1. Enter the disease or complications shock, or heart failure List only one cause complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine certificate be executed Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last the attending physiciar Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe 2 No 1 Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica the funeral director, 25. Was case referred to medical 26. Place of Death \_\_ eck only one) Be examiner? Hospital Other: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at w<u>ork</u>? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completely filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie icense number 29d. Date(signed (Manth, Day, Year) 30. Name and address of person wh completed cause of death (Item 23a) Type 31. Date filed (Month, Day, State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month
July Physician/ Melvin Williams James 2012 2:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. 1806 Middleborough Road Essex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 220-66-0660 1 XM 2 F Yrs March 9,1956 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City. Town or Location Director 1 Yes 2XX No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1806 Middleborough Road United States 21221 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Terminal Fork Lift Operator Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Milligan George Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1806 Middleborough Road Essex, Maryland 21221 Mrs. Connie S. Williams (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 8/4/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic Acense Michael L. Duda-Ruck Funeral Home of Dundalk, Neiser 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ENT Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated each) Examine Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be execut ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? After this certificate 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 OOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a Certifier 1 🛄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 2012 cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Betty Ruth Whitehair July 6:46 P M 2012 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Dundalk 3709 North Point Road 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Hours Director 1 □ M 2 😾 F 236-46-6678 March 24,1929 83 West Virginia Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director Dundalk MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21222 United States 3709 North Point Road hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Completed White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Years Homemaker Be not known 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Effie Roy Carrico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 ge 1 and 2 sl it of Health a If item 27 is 1827 Wildwood Ave. Baltimore, Maryland Sharon MacDonnell (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Department o Important: If any injury or 7/27/2012 Parkwood Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licencee Justin A. Jones Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failured ist only one cause on each line. Approximate Interval Between Onset and Death
Immediate Immediate Cause (Final Physician/ disease or condition Myocardial Infarction Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Vear Day Pregnant at time of death 1 Yes 2 g Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus Division of Vital Records, 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown ate has been signated based by 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 2 No After this certificate funeral director, pag 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes ဂ္ 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X□ Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death.

Director: After din by the further. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 171369 mans 12,00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaiser Permanente 4920 Campbell Blvd. Nottingham, MD Manish

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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 6:07 P M July 25, Anita Christine Wilson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Social Security Number Baltimore Towson er 1 Year If Unde 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) Country) 217-56-3797 1 - M 2 - X Director 62 Jan 3, 1950 28a-f show 10a, State 10b, County 10c, City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2000 No Halethorpe Baltimore 10e, Street and Number 10f. Zip Code 6 10g. Citizen of What Country? Funeral Itams 23a USA 4323 Leola Ave 21227 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or δ 1 XNever Married 2 Married 72 hours aftar Maryland 21215-0036 1 Yes 2xx No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filad within 7: Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည R. Christine Ramey E. Thurman Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 936 1st St. Brooklyn Park, HD 21225 Charles M. Wilson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery July 30, 2012 Brooklyn Park, MD 21. Sign of Fun ral Service Lipensee 22. Name and Address of Facility, P.A. Gregory Fink 426 Crain Hwy S., Glen Burnie MD M01148 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final andometrial Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a chad for usa as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached f g 🗌 Unknown g 🔲 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown tromagi peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed

or Attending Physician: The law requires that the death cartificate be executed Division of Vital Records, Completed paga 2 Aftar this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{X} \) Other (Specify) 2 No 읻 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA MOSPIGE To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th complately filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles ST MANUES  $\mathcal{M}$ AArun 31. Date filed (Month, Day, State are

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last 2. Pate of Death 3. Time of Death Mont eNe Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Baltimore Northwest Hospital - Seasons IPU If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 214-66-5741 1 🔀 M 2 🗆 F Yrs Nov. 21, 1954 New York or than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Woodbine Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21797 1737 Cattail Woods Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 호 Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Banking Federal Bank Clerk item 27 is marked ower other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed of Health and Mental Hitem 27 is marked of ဂ္ဂ Eva Jacob Richard Wiener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1737 Cattail Woods Lane Woodbine, MD 21797 Justin Wiener / son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any Injury or o 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Journey Crematory 7/31/12 4 Donation Final Woodbine, MD 21. Signature 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aha Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physician and ched for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death page 2 should be detached 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 No certificate 1 TYes 2  $\square$  No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မ 1 Yes\_ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death,

To the Funeral Director; After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 🗌 Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, )

who completed cause of death (Item 23a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Month Physician/ P M Marie Lucia Claudette Wadestrandt July 27 9:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 13843 Palmer House Way Silver Spring 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Days Min (Month, Day, Year) 73 Director 1 M 2 X F 057-34-6057 July 28,1938 Haiti r 28a-f show notified at 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Silver Spring MD Montgomery 0 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? pe ns 23a o r must b Funeral 20904 Haiti 13843 Palmer House Way within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Specify Bi-Racial 3 Widowed 4 Divorced Completed ال than "he. "he Medical F 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Real Estate Ith and Mental Hygien 27 is marked other the traumatic event, the Realtor Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumative filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Odette Bouillon Leon Wadestrandt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13843 Palmer House Way Silver Spring, MD 20904 Jacqueline Mallet-Cedeno/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 7/31/12 Woodbine, MD Signature of Juneral Service Going Home Cremation Service P.O. Box 784 M01651 MD 21029 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

1.5 years Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a noneequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Year Month Day 5 Other (specify) Pregnant at time of death per Yes 2 🔀 No 9 Unknown signed by till d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 🙀 Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 has 1 Yes 2 No 1 🗌 Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending iniury 1 X Natural

Division of Vital Records, P.O. Box 68760

State Registrar

in 24 hours after death.

In Funeral Director: All pletely filled in by the fu

within 2 To the F

Medical

Laura Hoffman, M.D. 8709 Flower Avenue Silver Spring, MD 20901 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation

determined

6 Could not be

Accident Suicide

3 🗆

29b. Signature and title of cer

4 Homicide

29a. Certifier

(Check

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

1 Yes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number D0071126

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 No

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month. Day, Year)

July 30, 2012

City or Town, State)

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	_		Registrar  1. Decedent's Nam	ne (First, Middle, L	ast)		Sitincate	2. Date of Death					0	3. Time of Death	£		
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inder	Examir		4a. Facility Name (i	f not institution, gi	ve street and numb								4c.	County of	Death		٦
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936	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	اھا		ried 2  Married	Armed Force 1 Yes 2 If Yes, Give Year or Date	2 🔀 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							Black, White, etc. Specify: White			
Maryland 21215-0036	72 hours in "natur Medical I	Completed		15. Decedent's ecify only highest	Education grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of							ind of Busin	ess/Ind	ustry	_
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Baltimore,	t. Page 1 tment of tant: If ii		1 <b>X</b> Burial 2 4 □ Donation	state C	cemetery, ci	ematory or o	ther place ry		Aug 2	, 2012	Bı			le, MD			
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Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?		irth 2 🗌 Feta ant at time of	al death 3	☐ Ectopic p☐ Other (sp	pic pregnancy					23d. Date of delivery Month Day Year			
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Division of Vital Records,	Atten	Certificate:	3 Suicide 4 Homicide	6 Could not	be 28e. Place o	f Injury - At ho	ome, farm, s			100 2 🗆					r Rural F	Route Number,	1
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	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check 2	2 💹 Medical Exa	nysician: To the bes miner: On the basis urse Practitioner: T	of examinatio	n and/or inv	estigation, in r	my opinio	n, death occ	curred at the	e time, date a	and place,	, and due to	the caus	e(s) and manner stated.	d.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ROL 11:53 PM MICHAEL 2012 Medical Jul 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death MEDSTAR HARBOR BALTIMORE N/A HOSPI If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 462-51-2032 **Director** Florida DECEMBER. 2 shov at 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Baltimore 1 Yes 20 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5245 Patrick Henry Drive 21225 U.S.A. ıral", or items ? | Examiner mus death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2X Married X Yes 2 No Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after Specify: White 1 Yes 2 X No Specify "natural", Yes, Give 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) 12th College (1-4 or 5+) Assistant Manager Wendy's Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Trenton Williams Dorothy Heaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Phyllis L. Williams / Wife 5245 Patrick Henry Drive Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of Department of F Important: If ite any injury or oth Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 07/31/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. terome 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END STAGE RENAL DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner VEI IHROMBOSIS Secue tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transi DIABET ES MELLITUS and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Physician: The law requires that the death certificate be SLEEP TRUCTIVE Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 🗀 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 G 2 No be detached the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral α 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier RESOD PG4-2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANOVER TREE State Registrar

DHMH 17 Rev 06-2011

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death 7974 Quail Ct. Glen Burnie Anne Arundel 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8 Date of Righ (Month, Day, Year) Days Hours Min. 217-46-3146 Director 1 🗆 M 2 🔀 64 Sept 3, 1947 MD Usual Residence of Deceder 23a or 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Glen Burnie Anne Arundel 1 Yes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7974 Quail Ct. 21061 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 XXNo Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Agent Insurance traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eugene Bailey Doris Perina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael II. Young 20a. Method of Disposition 7974 Quail Ct, Glen Burnie, MD 21061 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) July 31, 2012 Bayview Crematory Baltimore, MD Signary of Fungal Service Lice & 22. Name and Address of Facility
Fink Funeral Home, P.A. an y M01148 426 Crain Hwy s., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Onset and Death disease or condition TIPL CLEROSIS e ave Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): the attending physician the dornary Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this
completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 ☐ Accident
3 ☐ Suicide 5 🗆 Pending Investigation 1 🗌 Yes 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day 30 12 00036581 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth Month Young Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Jose 10LUSOM If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 19, 1919 **Funeral** 9. Birthplace (State or Foreign 172-18-9205 Director 93 1 □ M 2**X** F Pennsylvania or 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Md. Baltimore Edgemere 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2320 Gross Ave. 21219 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: White Completed 3

Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Secretary 12 years Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Steven Sabo Mary Vasas Vig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Young Son 7656 Old Battle Grove Road, Baltimore, Md. 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of July 27, 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 5 Other (Specify 2012 Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ovascular Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Kidney 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 2X No Other: 1 Npatient 2 -ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation Could not be 1 Yes 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number M. D. D0069989 ddress of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Registrar
DHMH 17 Rev 06-2011

State

JACKIE JONES,

3 1 2012

31. Date filed (Month, Day, Year)

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month (AA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1160 Mainsail Drive Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/02/1928 Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours Country) **Director** 1 DM 2 DF 068-24-3357 New York 83 show should be filed within 72 hours after death with the Manyland and Mental Hyglene.
1 is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Anne Arundel <u>Annapolis</u> 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1160 Mainsail Drive 21403 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married <sup>2 □</sup> \Rir Force 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) it. Page 1 and 2 should be filed withintent of Health and Mental Hygien retant: If item 27 Is marked other the njury or other traumatic event, <u>the</u> Commercial Pilot **Aviation** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick Zurmuhlen Katherine Horai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia A. Zurmuhlen / Daughter 1502 Coblestone Lane, Bellevue, NE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1 Department of Important: If it any Injury or o cemetery, crematory or other place, 1 Durial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/28/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. terval Betweenset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been approximated to the continuous and the co attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death signed by the at Id be detached for Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Whiknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2i ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 1 1 Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident
3 ☐ Suicide 1 ☐ Yes 2 ☐ No Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) Name and address of person EFENSE NF State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 1055AM 2012 Buddy Ray Age 07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cente HICOMICO TENINSULA If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 11/18/1934 217 30 8727 77 Director 1 M 2 □ F 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, <u>the Medical Examiner must be notified at</u> Director 1 Yes X No Worcester Snow Hill 10f. Zip Code 10g. Citizen of What Country? Funeral 206 Ironshire St. IISA 21863 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 K Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Own Business television repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Lee Age Bonnie Bates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 206 Ironshire St. Snow Hill MD 21863 Kathy A. Gravenor (daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1st State Crematory 7/16/2012 Millsboro, DE 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 vice Licensee 21. Signature une Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Physician/ Devale disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) signed by the attending physician and doe detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the control of the cont IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မှ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or invariant in the cause of examination and or invariant in the cause of examination and/or invariant in the cause of examination and or in Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 131 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 EAST CARROLL STREET, SALISBURY, MD 21801 NICHOLAS L. OGBURN DN 2+ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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	State of Maryland / Department of Health and Mental Hygiene	2012	0

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*ny		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
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Baltimo permit. Page Department o Important: injury or ott		The state of the s	and Address of activin	1	Silver Spri	ing, MD
iii Marka		James a Sols 1500	University Bl	vd. W., S:	ilver Sprin	ng, MD 20901
Physician Medical		23a. Pan. Enter the disease, or complications that consed the death. Do not enter the m failur. List only one cause on each line.	ode of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
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cords, P.O. Box 68' law requires that the death certifi has been signed by the attending 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e, Did toba	cco use contribute to the	ne cause of death?
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ital sician:	å	25. Was case referred to medical examiner?  1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Chec			
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Division of Vital Records, To the Bospital or Attending Physician: The law requir within 24 hours after death. The the Funeral Director: After this certificate has been st completely filled in by the funeral director, page 2 should the	Certification:	3 Suicide 4 Homicide 6 K Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, fact (Specify)  7 Fd: Top landing	ctory, office building, etc.	28f. Location (Street or Town, State	eet and Number or Rura e3803 34th S	al Route Number, City Street
To the Hosp within 24 ho Tn the Fune	ledical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a cone)  2 Medical Examiner: On the basis of examination and/or investigation, in	at the time, date and place, ar	nd due to the cause(s	s) and manner as stated	d.
To t With Th t	Med	and manner stated.  29b Signature and title of certifier	29c. License number		9d. Date signed (Mont	
		MI Comment	O.C.M.E.		July 17, 2012	, Juj, . caij
	Ì	30. Name and address of person who completed cause of death (Item 23a)				
			Baltimore Street, Balti	imore, MD 2122	3	
St Regist	ate rar	31. Date filed (Month, Day Year) 22. Registrar's Signature				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 07 Physician/ 10:35P M 2012 Alexander Savoy Mary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b City, Town, or Location of Death Examiner Coastal Hospice at the Lake Wicomi Salisbur a 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) 578-28-9888 Director 1 1 M 2 X F 07/29/1922 Virginia 89 Usual Residence of Dece 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "nature!", or items 23a or 28a-f showing injury or other treumetic event, the Maddel Examiner must be notified at enter the most be not the most be not the most be not the most beautiful and the most 10b County 10c. City, Town or Location Director 1 Yes 2 X No Maryland Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Numbe by Funeral USA 21842 12719 Whisper Trace Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Child Care Provider 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Malissia Plunkett Edward Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12719 Whisper Trace Dr., Ocean City, MD 21842 Joyce A. Thomas/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 7/17/2012 Suitland, MD Cedar Hill Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee HOITOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition ARDIOMYOPATHY Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 1 🗌 Yes ZINO 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation ☐ Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TC ひ HellAur 1/20 31. Date filed (Month, Day, Year)

Registrar

State

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ July 11 8:15P William Joseph Amari Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Talbot 4b. City, Town, or Location of Death **Examiner** Genesis Health Care The Pines Easton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) 1932 New York 1 🗓 M 2 □ F Days Hours 80 124-22-4841 Director Usual Residence of Decedent or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No East New Market Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21631 IISA 208 Railroad Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1  $\times$  Yes 2  $\longrightarrow$  No 1950- If Yes, Give 1974 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced 1974 White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Marine Supply Manager Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) lliam မ Filipps Amari Elenora Truglis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 125, East New Market MD 21631 Susan Jones-Amari/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Crematory Of Delmarva 4 Donation 7/13/2012 Delmar, Delaware 5 Other (Specify) Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD . Sign tupe of Funeral Service L 21631 Part 1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death RENAL Immediate Cause (Final STAGE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 115 cardiomyo Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2200 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an purtension autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital 2 No 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 35 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier 29d, Date signed (Month, Day, Year) 2093858

Registrar
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death Physician/ Month 7 – 15-Doris C. Brickhouse 12 2:05a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George Bradford Oaks Nursing Home Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days (Month, Day, Year) 79 218-34-5123 **Director** 1 🗆 M 🚈 F 8-5-32 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Prince George Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 2521 Corning Ave. IISA Apt. death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than College (1-4 or 5+) other traumatic event, the Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H. Butler James G. Goldring Cecelia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 sh ment of Health a tant: If item 27 is 2521 Corning Ave Apt 1 Fort Washington Charles Brickhouse-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 XBurial 2 Cremation 3 Removal from State St.Marys Church 4 ☐ Donation 5 ☐ Other (Specify) 7-30-12 Bryantown Maryland Signature Vuneral Service L 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco Md 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Due to or as a consequence of Examiner Sequentially list conditions, Examine Duri to for as a nonsequence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last trar Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 1 Yes 2 X No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 W No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending ours after death.

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filled in by the fu Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours a Medical 29a. Certifier within 24 hor To the Fune completely fi 🗪 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Number Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certification 29c. License number July 17, 2012 D35206

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Registrar

DHMH 17 Rev 06-2011

11701 GVIUSShu Road. Fort WASHIYM MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician/ C 9:15a M Bernice Butler Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6203 Hemlock Clinton Prince George Way Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) 1 □ M 2 🕇 F **Director** 214-42-2676 68 12-26-1943 Maryland Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No Maryland Prince George Clinton 10e. Street and Number ms 23a or ō 10f. Zip Code 10g. Citizen of What Country? Funeral 6203 Hemlock Way 20735 USA r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Visual Info. Specialist Federal Government of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence Walls Essie Savoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 i 6203 Hemlock Way, Clinton Md 20735 Thomas Butler Sr. Husband altimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ò Department of Important: If any injury or once. Resurrection 7-20-12 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signatur 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused he shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Penesicius/ disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-trar and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atte in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence After this 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury Natural work? 1 \sum Yes 2 \sum No 5 Pending s after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number Jocelyne D63748

State Registrar 31. Date filed (Month

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Home

2013 TOD DOB 01/01/1977 DOD 07/13/2012 Burns, Joseph C

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		216-14-5215	6. Sex 7. Ag	e (In yrs. Ia	st birthday) Yrs.	If Under 1		If Under 2	4 Hrs. Min.	8. Date of Bir (Month, Da July 22	th ly, <i>Year)</i> 2, 1	.920	Countr	ace (State or Foreign y) yland	
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that th ned by e detai	y Pł	Part II. Other significant condition	-		_	nderlying ca	iuse giv	en in Part I.		23e. Did t	obacco	use contri	bute to the	cause of death?	
equires een sig ould b	ted t	DIAMERES	MELL	174	5					1 🗆	Yes 2	2 🗆 No	3 🗌 Proba	ably 4 Unknown	
ysician: The law require is certificate has been si director, page 2 should	Completed									24a. Was auto perfo	psy ormed/?	p	rior to com eath?	sy findings available pletion of cause of	
an: Th rtificate	Be Co	25. Was case referred to medical					26. Pla	ace of Death	(Check	1 L Yes	2 1	No 1	☐ Yes 2	! ∐ No	
hysici this cer al direc	ပ္	examiner? 1  Yes 2 No			R/Outpatien			4 □ Nur	sing Ho	me 5 Resi	dence	6 🗌 Othe	r (Specify)		
ding P th. After t funera	cate:	27. Manner of Death  1			28b. Time of injury	28c	c. Injury work'	rat ? Yes 2 □ N		28d. Describe I	now inju	iry occurre	d		
f or Atten after dea Director: d in by the	Certificate:	3 Suicide 6 Could r 4 Homicide determi	not be 28e Place of Ini							28f. Location (S City or Tov			r or Rural F	Poute Number,	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical E	Physician: To the best of caminer: On the basis of control of the basis of the basi	examination	and/or invest	igation, in m	y opinio	n, death occ	urred at	the time, date a	and plac	e, and due	to the caus	e(s) and manner stated	
To the within com		29b. Signature and title of certifier	mer n	1D		29c. I	License	number	99	46	29d. D	ate signed	(Month, Da	ay, Year) 2012	
13		30. Name and address of person v	ho completed cause of c			1	A	1Pus	2	) 11/	-C. 75	250	SWW	mm	
Stat	te	S1. Date filed (Month, Day, Year)	32. legistr	ar's Signati	MEDIC	and A	A. JAA	1147	TN	, m	7	1/2/	UWW	7.40)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bittner Month Allen James 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** raiona lan Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Months Min Country) 214-90-4557 44 1 🛣 M 2 🗆 F **Director** Maryland 04/11/1968 show r 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Corriganville Allegany MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r must be r ò 11121 Newton Street (P.O. Box 352) 21524 with 1 Funeral USA nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items, or other traumatic event, the Medical Examiner mus Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Bace - American Indian Armed Forces þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Drywall Hanger Be 18. Mother's Name *(First, Middle, Maiden Surname)* Jacqueline Lee 17. Father's Name (First, Middle, Last) Chandler မ Bittner Lee James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 352, Corriganville, MD 21524 Sherry J. Bittner / Ex-wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Restlawn Mem. Gardens 07/05/2012 LaVale, MD Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Rome, P.A. of Funeral Salvice Lisensee 404 Decatur Street, Cumberland, MD 21502 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final Physician/ reston disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** rocher Secure tielly list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami signed by the attending physician and defeached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be with 24 hours after death.

the Funeral Director; After this certificate has been signed by the attending physicia P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Other (specify) Day Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital ٥ Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat, 29d. Date signed (Month, Day, Year) Marrolow AN 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COMBBRIAND, MO nes WILLOWBROCK 12500 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18:50 Mary Beth Elizabeth Bevan Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Western MD Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral Director** 93 August 17, 1918 220-07-6572 1 M 2 X F Maryland Yrs Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 65 Mount Pleasant St. Funeral 23a with U.S.A 21532or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give "natural", 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Emma Gatehouse **Edward Davis** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai 19956-Delware Ann Davis 508 Pine Street Laurel Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park July 07, 2012 Frostburg Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Inhola 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ventricular Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Box 68760 use as attending IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy signed by the atter in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has h autopsy performed? Yes 2 No death? 2 🗌 No 1 Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ည 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending **X** Natural injury 1 Yes Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 10 FIN Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

NLS

32. Registrar's Signature

1/00

MD 2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carolyn Erma Bryant July 2012 4:35 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 723 Bald Eagle Lane Calvert Lusby Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Hours West Virginia 10/31 Director 234-58-7751 73 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland | Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 723 Bald Eagle Lane 20657 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married ģ 1 Yes If Yes, Give 2 🔛 No Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: "natural", 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72. In and Mental Hygiene.
7 Is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Human Service Aide MD State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur C. Board Madge Marie Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra Carolyn A. Noonan / Daughter 723 Bald Eagle Lane, Lusby, MD 20657 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 07/20/2012 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ ancrea Cancel disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Year Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N Director: After this certificate has 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 XNo Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Funeral Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number July 16, 2012 D47066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, MD 22650 Cedar Lane Court, Leonardtown, MD 20650 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ 12, Cyrus D. Boyd July 1:57 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince Georges Southern Maryland Hospital 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours **Director 1X** M 2 □ F 577-62-1126 63 10-30-1948 North Carolina Usual Resi 28a-f shov 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director must be notified 1X Yes 2 □ No Md. P.G. Clinton 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6902 Surratts Road 20735 U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 5 1 Never Married 2 Married þ 2 XNo 1 Yes If Yes, Giv Maryland 21215-0036 Black 1 Yes 2 X No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 4 Programmer Private if Health and Mental Hygi item 27 is marked other other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Boyd, Jr. Cyrus Jessie Shearie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Delia Boyd - Wife 6902 Surratts Road, Clinton, Md. 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important; If is any injury or conce. 1 Burial 2X Cremation 3 Removal from State 07-18-2012 | Riverdale, MD 4 Donation 5 Other (Specify) Riverdale Pk Crem. 2 Ignatu of Funeral Service Li Ausee 22. Name and Address of Facility Ronald Taylor II Funeral Home Koundal 10583 Middleport Lane, White Plains, Md. 20695 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Onset and Death Immediate Cause (Final Physician/ tNOXIC disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown be detached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No ည Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No completely filled in by the Investigation Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

only one

29b. Signat

Registrar DHMH 17 Rev 06-2011 (Item 23a) (Type, Print)

503

who completed cause of

Certifying Nurse Practitioner: To the jets of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MARATTS ROAD. CLINTON MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of Ma	ıryland				and Me		71	012	24271
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Ph	nysicia	n/	Nancy Gregory Ba							Month July 1		Year	3. Time of Death 3:10 P M
	Medic xamin	_	4a. Facility Name (if not institution, give s				4b. City. Tow	yn, or Location		July I	4c. County		3.10 1
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Fu	ıneral		5. Social Security Number 6. Se	x 7. Age	(In yrs. las	st birthday)	If Under 1 Y		24 Hrs. 8	B. Date of Birth (Month, Day	h ( Year)	9. Birthp Count	lace (State or Foreign
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pu .	how at	'n	Usual Residence of Decedent  10a. State 10b. County			, Town or Loc				12/0//			0d. Inside City Limits
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P, N and 2 Health	em 27 her ti		-		Lank Di	10430 ace of Dispos					MD 2085		Charles Charles
<b>Saltimore,</b> bermit. Page 1 and Department of Hea	Important: If ite any injury or ot once.		20a. Method of Disposition  1  Burial 2 Cremation 3		ce	emetery, crem	atory or other	r place)	7/16/		20c. Location Falls	-	
II <b>TIIT</b> nit. Pa artme	ortani injury e.	-	4 Donation 5 Other (Specify  21. Signature of Funeral Service License		Nat	ional					vler's S		
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cords, P.O. Box	ned b	by P	Part II. Other significant conditions co	ntributing to death bu	ut not resu	ulting in the u	nderlying cau	ise given in Part	t I.	23e. Did to	bacco use con	tribute to th	e cause of death?
dS,	en sig ould b									1 🗆 '	Yes 2 No	3 🗆 Prob	pably 4 🗆 Unknown
aw rec	as be	Completed								24a. Was autop	osy	prior to con	osy findings available mpletion of cause of
He T	cate h	Con								1 Yes	rmed? 2 KNo	death?	2 <b>X</b> No
ician:	certific	Be	25. Was case referred to medical examiner?  1  Yes 2  No	lospital:				26. Place of Dea					
Phys	r this eral di	인 :a	27. Manner of Death	28a. Date of injur	у	ER/Outpatien 28b. Time of		Injury at			dence 6 Oth		)
on C ath.	r: Affe	icat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day	; Year)	injury	М	work? 1 Yes 2	□ No				
Division of Vital Records, tal or Attending Physician: The law requires after death.	recto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju			et, factory, of	ffice	28	3f. Location (S	Street and Numb	per or Rural	Route Number,
DIV Dital o	iral Di		4.50						340				
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death.	Fune letely †	Medical	(Check 2 Medical Exami		kamination	and/or invest	igation, in my	opinion, death of	occurred at the	ne time, date a	ind place, and di	ue to the cau	use(s) and manner stated.
To the within	To the	Σ	29b. Signature and title of certifier		_	, mowiedye,		icense number	Les and place		29d. Date signe		
	20		1 Gran	mo, m,	K)		20	057	124		71	1211	۷
			30 Name and address of person who c	ompleted cause of de	eath (Item	23a) (Type, P	rint)	06 Roc1	cvilla	мп 2	0850		
	O.		Truong Bao MD 10 31. Date filed (Month, Day, Year)	200 Degistra	r'a Clanat	LIKO		.oo Rock	~ ~ 1116	۷ سد و			
. R	Sta Registra		JUL 1 6 2012	Service Service	1.	park	7						

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2

vonte Jamar Br		State of Maryland /	Department of	Health and Mental H		201	2 21.27			
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	Certificate of	Death	Reg	g. No. 4 0 1	3. Time of Death			
Medical Examir		Avonte' Jamar	Brow		Month July 21, 20		0658 hrs			
		4a. Facility Name (if not institution, give street and number)  Peninsula Regional Medical Center  4b. City, Town, or Location of Death  Salisbury  4c. County of De  Wicomico								
Funeral		5. Social Security Number 6. Sex 7. Age	rs. 8. Date of Birth	Birth(MM/DD/YYYY) 9. Birthplace (State or						
Director		878-22-6491 1×M 20F 10	Days Yrs.	Months Days Hours Mi	n. July 1	1, 2012 Foreig	untry) M.D.			
<b>h</b>	ļ	Usual Residence of Decedent	Oc. City, Town or Locati				10d. Inside City Limits			
inw any				noke City			1 Yes 2 No			
with the Maryland ms 23a nr 28a-f shnw be notified at once.	Director	Maryland Worcester  10e. Street and Number	1000	10f. Zip Code	10	g. Citizen of What Cour				
the M		2003 Cropper Ct.		21851		U.S. A	4			
th with	Funeral	11. Marital Status  1		s Decedent of Hispanic Origin? ( see, specify Cuban, Mexican, Puerl		14. Race - Americ	can Indian, Black,			
72 hours after death with the Maryland n "natural", or items 23a nr 28a-f sh sal Kaminer must be notified at once		Widowed 4 Divorced If Yes 2	No	Yes 2 1 No specify:		Specify: R	ack			
ours aff		15. Decedent's Education (Specify only highest grade comp	leted) 16a. Deceden	t's Usual Occupation (Give kind of		16b. Kind of Business/I				
15-0036 He within 72 hour Hygiene. d ather than "natu	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	)	ost of working life, DO NOT use re						
within giene.	E.	17. Father's Name (First, Middle, Last)	Nev	1er worked 18.Mother's Nam	o /Eirst Middle M	None				
MD 21215-0036 2 should be filed within 7 th and Mental Hygiene. 27 is marked ather than umatic event, the Medica	Bec	Arron Brown Jr	4	Rays	ihim a	Schoolfie	e 1d			
21. sould b d Men is mar		19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	Address (Street and Number or	Rural Route Numb	oer, City or Town, State,	Zip Code)			
MD and 2 sho alth and im 27 is	-	Rayshima Schoolfield-mo	ther 200	3 Cropper C	+. Pocom	ake City MI	S, 21851			
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,		1 1 Burial 2 Cremation 3 Removal from State	crematory or oth	ner place)	120/12	20c. Education - City of	Town, State			
ltim it. Pag rtment ortant;	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Coulspring	er place)  V.M.C. Cem.  ame and Address of Facility	1 681 12	Girdlet	ree, MU,			
Ba perm Depa Imp		Al	3	0639 Hampd	en Ave	frincess A	nne.MD 21853			
Physician		23a. Part I. Enter the disease, or complications that caused th failure. List only one cause on each line.	e death. Do not enter th	ne mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approxima e Interval Between Onset and			
Examiner		Immediate Cause (Final disease a. Sudden Neor					Death			
7.1		or condition resulting in death)  Due to (or as a consequentially list conditions,	uence or):							
~	iner	if any, leading to immediate Due to (or as a consequence of the control of the co	uence of):							
=	Examiner	(Uisease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conseq	uence of):							
	dical E	d.	27	g931 9-18-12 sm						
te be e	ğ	F FEMALE: 23c. If yes, outcome		8331 3-10-17 Sm		23d. Date of delivery				
5876 srtifica ling ph	an/N	3b. Was decedent pregnant in the past 12 months?	2 Fet	al death 3 Ectopic pregr	nancy		ay Year			
Box 68760, c death certificate b the attending physical control of the attending physical control of the burner of the burner as	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	ne of death 5 Oth	ner (Specify)						
that the d			out not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?			
s, P.O. ires that the signed by	d by	-			1 Yes	2 No 3 Prob				
cords law requi	plet				24a. Was ar autops	y prior to co	opsy findings available ompletion of cause of			
tal Rec	Completed				perform 1 Yes 2		s 2 No			
ician: ician: s certif rector,	Be	25. Was case referred to medical examiner?	2 ✔ ER/Outpatient	26.Place of Death (Check 3 DOA Other Nurs		tesidence 6 Other:				
n of Viling Physical After this funeral direction	앍	27. Manner of Death 28a. Date of Injury	28b. Time of Ir			ow injury occurred				
ion (tending eath.	tio	1 X Natural 5 Pending (Month, Day, Year Accident Investigation	r)	1 Yes 2 No						
Division of Vital Records, pital or Attending Physician: The law requirement after death.  In the law rector. After this certificate has been stilled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be 28e. Place of Injur	y - At home, farm, stree	t, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rur	al Route Number, City			
ospital hours unceral		4 Homicide determined (Specify)			1					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	dical	(Check only 2 Certifying Physician: To the best of my keone) 2 Medical Examiner: On the basis of examination and manner stated.	- '							
F 2 F 8	Medi	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)			
		( Anterlil)		O.C.M.E.		July 22, 2012				
		<ol> <li>Name and address of person who completed cause of dea Laron Locke MD. Assistant Medical Exam</li> </ol>		Itimore Street, Baltimore,	MD 21223					
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's								
Regist		JUL 2 6 2012	~ B. pe	~						
DHMH 17 Rev 1/20	01		ORIGINAL							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ Day 2012 Teresa Bayotlang-Loga 11 10:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring 622 Wayne Avenue Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 216-23-5510 1 M 2 A F 53 Yrs. 6, 1958 Philippines Aug. Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.
Item 27 is merked other then "naturel", or Items 23e or 28a-f ehow other than the markle event, its Medical Example and the natural forms and the contribution. 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits Director MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 622 Wayne Avenue 20910 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?...
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed ar or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file end Mental H is merked o Antonio T. Bayotlang Leonor A. Cuago 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pedro A. Loga/Husband 622 Wayne Avenue, Silver Spring, MD 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 s Department of H Importent: If ite any Injury or ott 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State  $\frac{\text{July}}{201}$ Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Uterine Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ed by the attending physician and deteched for use as the burlal-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. To the Funerei Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Month 5 Other (specify) Day Year P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed I 23e. Did tobacco use contribute to the cause of death? ۵ Records, 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 Yes 2 No Division of Vital completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🛭 Residence 6 C Other (Specify) မှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D29142 5 July 12, 2012 30. Name and address of perso ompleted cause of death (Item 23a) (Type, Print) #205 Charles Boice, MD 10301 Georgia Avenue, Silver Spring ,MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JUL 13 ZUIZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 1804 Bowman Dr. Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 214-46-0133 Country) Director 1 X M 2 □ F Yrs Nov 20 1945 66 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1804 Bowman Dr. 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Black 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Concrete Finisher Neal Concrete Co. 10th 0 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ည Melvin L. Brown Gladys Booze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Bradford(Friend) 1804 Bowman Dr. Annapolis, Md. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 7-10-12 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenser Winname Reverse of SaciliSons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b director, page 2 s autopsy performe death? 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 1 Yes 2 🗌 No the Investigation 6 Could not be á Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investination in my online, death occurred at the time. Medical 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of dertifier 61 31. Date filed (Monti State

DHMH 17 Rev 06-2011

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CORGIA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Arbor at Baywoods Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 577-30-2275 Director 1 M 2x F 87 Michigan 9/19/1924 r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Direct Annapolis Maryland Anne Arundel 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21403 USA 7101 Bay Front Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ X Yes 2 □ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify should be filed within 72 hours aft and Mental Hygiene.

is marked other than "natural", 3<sup>¥</sup> Widowed 4 ☐ Divorced Specify: Completed Year or Dates. WWII White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Adaline Schick George Carroll Dyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6819 Stockwell Manor Drive, Falls Church, VA 22043 Weston D. Burnett - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/18/2012 Baltimore Crematory Baltimore, MD 21. Signature of Funeral Service License John M. Taylor Funeral Home 22. Name and Address of Facility Myclin T. Klobert 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ansa and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home ည 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Date signed (Month, Day, Year) XX 30. Name and address of pers npleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 10 2012 Registrar

DHMH 17 Rev 06-2011

P.O.

12-05490 Blair Brian Boyd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Blair Brian Boyd		1- For State Registrar	St	ate of Maryla		artment of		d Menta	al Hyg		21	012	2 2427
Physicia Medical Examin		Decedent's Name		<sub>e,Last)</sub> ian Boyd				<del> </del>		Date of Dea Month July 22, 2	Day Year		Time of Death
		4a. Facility Name (i 9504 Old Ar		n, give street and nun oad	nber)	-	b. City, Town, or L Ellicott City	ocation of			4c. County of Howard	f Death	-
Funeral Director		5. Social Security N 213-17-70	060	6. Sex	7. Age (In yrs. 38	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir	th(MM/DD/YYYY) 1973	9. Birthp Foreign Coun	
Maryland 28a-f show any d at once	lor	MD	10b. County Howa	rd	10c. City	, Town or Locati	on riendship	<b>-</b>				- 1	0d. Inside City Limits  Yes 2 No
ith the Mary 23a or 28a notified at	al Director	10e. Street and Nur  3212 Par  11. Marital Status					10f. Zip Code 21794				Og. Citizen of Wha	l Sta	ates
P	by Funeral	1 Never Marrie 3 Widowed	4 Dive	1 Yes	ces? 2 X No	1	s Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, F	uerto Ri	ican, etc.)	White,	etc. V	n Indian, Black, White
0036 within 72 hour ene. er than "natu	Completed	Elementary/Secon	ndary (0-12)	ify only highest grade College (1-		during mo	's Usual Occupations of working life. I	DO NOT us	se retired	1)	16b. Kind of Bus		ustry
21215-0036 Muld be filed within 7 Mental Hygiene market other than te event, the Medica	To Be Co	17. Father's Name ( Blair A.  19a. Informant's Name	Boyd			19b. Mailing	Address (Street	Pat	sy A	A. Via	Maiden Surname)	State 7	in Code)
e, MD I and 2 sho Health and item 27 is		Patsy V.	Boyd	- Mother		3212 Place of Disposit	Parliame:	nt Pl	.ace	West I	riendshi	ip, M	1D 21794
Baltimore, MD 21215-005; permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene Important: If item 27 is market other injury or other traumatic event, the Med		1 K Burial 2 4 Donation 5 21 Signature of Fun	Other Sp	3 Removal from ecify:	Otate		Cemeter			3/2012 7 H. Wi			City, MD Ly FH Inc.
Physician /Medical		23a, Part I. Enter the failure. List only	disease, or o	complications that cause each line.	ised the death.	411	2 Old Co	lumbi	a Pi	ke Ell	Licott Ci	ity,	MD 21043 Approximate Interval Between Onset and
Examiner		Immediate Cause (F or condition resulting	g in death)	Due to (or as a c			epoxide I	ntoxi	cati	ion	31		Death
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  a) Director: After this certificate has been siled in by the funeral director, page 2 should be attitication. To Bo Completed	0	27. Manner of Death  1 Natural	No Sendi	28a. Date of (Month, D	Injury ay,Year)	ER/Outpatient 28b. Time of Inj	ury 28c. Injury	ther <sub>4</sub> N	ursing H	ome 5 F d. Describe h			ene
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To the H within 24 To the F complete	wearca.	(Check only one) 2 1 N	ledical Exam	iner:On the basis of and manner stat	examination ar	nd/or investigatio	n, in my opinion, d	leath occur	red at the	e time, date a	nd place, and due	to the ca	
		30. Name and address	ss of person w	ho completed cause	of death (Item	23a)	O.C.M.	E.			July 23, 2012		
⊋ Stat		Donna M. Vir	ncenti, MD	Assistant Me	dical Exam	niner 900 V	V. Baltimore S	treet, Ba	altimor	e, MD 212	223		
Registra			UI 24	ZUIZ 1 /4	eur.	A. Bas	11						

			AMEND #25, PER MD	ype or Pri	nt in B	lack In	delible In	<b>k. Ens</b> Health	ure All and Me	<b>Copie</b>	s Are	e Legible	Э.		
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ممسد	Examin	er	4a. Facility Name (if not institution, give str  PUNINGULA ALGIONA  5. Social Security Number  6. Sex	N Medv	VAL CALLY SALISBURY						4c. County of Death  NICS MICS				
	Funeral Director			M 2 □ F	56	Yrs.	Months Days	Hours	Min.	Date of Bir (Month, Da EB • 28					
	daath with tha Marylend Items 23a or 28a-f show her must be notified at	ctor	10a. State 10b. County			Town or Loc	ation						10d	. Inside City Limits	
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	items		11. Marital Status	2. Was Decedent E Armed Forces?	er in U.S.	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yell f Yes, specify Cuban, Mexican, Puerto Rican,						14. Race - An			٦
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mantel Hygians. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Mudical Examiner must be notified at	Completed by	1 🕅 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗆 Divorced	1 X Yes 2 If Yes, Give Year or Dates.		1	☐ Yes 2 🛣 No	Specify:		ari, etc.)		Black, White, etc. Specify: WHITE			
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تِ	ould b		GEORGE A.  19a. Informant's Name/Relationship (Type		KMANN		A.I.I. (O) 1		ANET		STRO				-
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Baltimore,	1 and of Heal of Heal		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		20b. Plac	ce of Dispos	ition (Name of atory or other place		Date			Location - City or Town, State			1
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Bal	permit. Paga 1 Department of I Important: If it, any injury or or		21. Signatur Weneral Service Licen	4			Name and Addre		•	F SF	T.RVV	T.T.T.	DE	19975	
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687	ath certificate ba axacutad attanding physician and for usa as the burlal-transit	W/u	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome								23d. Date of c	leliven.		1
Box 68760	daath na atta ad for	by Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 4 Pregnant a			Ectopic pregnand Other (specify)	Э				Month	Da	y Year	
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Division of Vital Records,	To the Hospital or Attending Physician; The law requiras that tha daath certificate ba within 24 hours aftar daath to the same within 24 hours aftar daath. To the Luneral Director Aftar this cartificate has tean signed by tha attanding physici complataly filled in by tha funeral director, page 2 should be datachad for usa as the but the but the same same the same same same same but the same same same same same same same sam	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc		e, farm, stree	et, factory, office		28f.	Location (S City or Tou		d Number or F	ural Ro	ute Number,	
	ospita hours unerai ily fillac	Medical	29a. Certifier 1 Certifying Physici	an: To the best of	my knowled	lge, death oc	curred at the time	e, date and	place, and d	ue to the ca	ause(s) a	nd manner as	stated.		1
	To the Hospital or within 24 hours afte To the Funeral Dir complataly fillad in	Me	(Check 2   Medical Examiner	: On the basis of e	xamination a best of my	ind/or investion knowledge o	gation, in my opinio death occurred at t	on, death oc he time, dat	ccurred at the	time, date a	nd place	, and due to the	e cause	ed .	
	<b>₽</b> ₹ <b>₽</b> 8		29b. Signature and title of certifier	4-11			29c. License	e number	11		29d. Da	te signed (Mor	ith, Day ز- مسسد	Year)	
	A. MIL	3 d	30. Name and address of person who com	pleted cause of de	eath (Item 2	3a) (Type, Pri	int)	2041	71			, ,,		~ / /	4
	Ni		29b. Signature and sittle of certifier  30. Name and address of person who com  Seph Raffetto  31. Date filed (Month, Day, Year)  12 2012	m.D.	P.R.M	1.C.	00 E. Ca	rrol	15+.	Sali	sh	Lry	mA	21801	
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Princip Market	Examir		4a. Facility Name (if not institution, give s ATLANTIC GENERAL				4b. City, Town, or BERL		ath	4	c. County of	Death CESTE	ER	
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	/land f shov ed at	ţoţ	10a. State 10b. County		10c. City,	Town or Loc	cation		-			100	d. Inside City Limits	
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36	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Armed Forces  1  Yes 2 N If Yes, Give Year or Dates.	?		Vas Decedent of H	ispanic Origin? In, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	-	14. Race -		o.	
2-00	hours natura dical E	olete	15. Decedent's Ed (Specify only highest grad	ucation		16a. Deced	lent's Usual Occup	ation	vorting	16b.	. Kind of Business/Industry			
21215-0036	within 72 giene. Ier than '	Completed by	Elementary/Secondary (0-12)	College (1-4 or	5+)	life. DO	HOMEMAKE		rorking		OWN	WN HOME		
Maryland	should be filed within 72 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Mec	To Be	17. Father's Name (First, Middle, Last)  JESSIE  T•	WILKE	ERSON			18. Mother's N	lame (First, Middle E	e, Maider EVAN				
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	and 2 s Health Item 27 other tra		DANIEL W. CATHELL 20a. Method of Disposition	SK./EXEC	20b. Pla	ace of Dispo	sition (Name of		BEKLIN,	_	YLAND _ocation - Ci			
Baltimore,	Page nent o ant: If ary or		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from Stat	.0	LE CEM		7/	12/12	WH	ALEYV]	LLE,	MARYLAND	
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90	cate be executed physician and s the burial-transit													
. Box 68760	ath certifications attending for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcom 1  Live Birth 4  Pregnant 9  Unknowr	at time of de	death 3 [	Ectopic pregnand	ру			23d. Date o		y ay Year	
s, P.O.	requires that the desorters is should be detached	d by Pr	Part II. Other significant conditions co	ntributing to death	but not resul	lting in the u	nderlying cause giv	ven in Part I.					cause of death?	
of Vital Records,	The law requate has been page 2 shou	complete								opsy formed?	prid dea	r to com	y findings available pletion of cause of	
tal	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			26. Pl	ace of Death (C						
of Vi	Physic r this c eral dir	9: To	1 ☐ Yes 2 ☐ No Control of Death	1 Inpa 28a. Date of in	itient 2 E	28b. Time of	t 3 DOA	4 L. Nursin	Home 5 Res	·		Specify)		
on c	anding Ph sath. rr: After th	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, D	ay, Year)	injury	M 1 🗆	? Yes 2 🗌 No						
Division	al or Attendin s after death. Il Director: Aft ed in by the fu	Certificate:	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At hon etc. <i>(Specify)</i>	ne, farm, stre	eet, factory, office		28f. Location City or To			r Rural R	oute Number,	
	To the Hospital or Attenc within 24 hours after deati To the Funeral Director: Sompletely filled in by the	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examir	er: On the basis of	examination	and/or invest	igation, in my opinio	on, death occurre	ed at the time, date	and plac	e, and due to	the cause	e(s) and manner stated.	
	Northi Northi		29b. Signature and title of certifier	MD			29c. Licenso	08 2-6	>	29d. D	ate signed (A	Nonth, Da	y, Year)	
_	5		30. Name and address of person who co	04 0	17-33	> H+	Eath.	Jay j	or Be	+4	nM	D 2	4811	
J.	Sta	te	31. Date filed (Month, Day, Year)	3 egist	trar's Signatu	1 60	ake							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 45 AM Month Year Physician/ Faye E. Beckett 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Agnes Baltimore HOSOITA ALTIMOVE 9. Birthplace (State or Foreign 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 220-66-4566 Director 1 🗆 M 2 🔀 F June 8, 1957 MD 55 Usual Residence of Dece 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 X Yes 2 No Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 833 Lyndhurst 21229 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 **N**O Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Store 12 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Nancy Dennis Walter Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16147 Sherwin Ct., New Freedom, PA 17349 Rodney Beckett, Jr./son 20b. Place of Disposition (Name of cemetery crematory or other place)
Crematory of Delmarva 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7/16/2012 Delmar, DE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home, 1618 West Rd., Salisbury, MD aude Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** ardisvesco ler theroscies Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a surraequence of attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has filled in by the funeral director, page 2 performs 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 🗌 Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural injury 5 Pending Accident 2 No Investigation within 24 hours after death

To the Funeral Director: /
completely filled in by the i 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 50283 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Baltimore MANYLAND ST Hospital OOPENMA

DHMH 17 Rev 06-2011

State

Registrar

Date filed (Month, Day, Year)

JUL

13 2012

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\mathbf{J}_{\mathbf{u}}^{\mathsf{Month}}\mathbf{y}$ 5, 2012 George W. Burgess 23:00 P M Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Clinton Southern Maryland Hospital 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Rirth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Director 1 X M 2 - F 251-50-1050 Nov. 12, 78 1933 South Carolina 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No Bowie Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20721 United States 11604 Marjorie Drive 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No hours after Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify 3 ☑ Widowed 4 ☐ Divorced Specify: Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene 6th Cab Driver Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Weston Burgess Liza Brown and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11604 Marjorie Drive Bowie, Maryland permit. Page 1 and 2 Department of Healti Important: If item 2: any injury or other the Lucretia Robinson - Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State July at 12, 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2012 Ft. Lincoln Cemetery Brentwood, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility John T- Street M00560 4001 Benning Road NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SEPSIS Ph sician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner NEUMON (A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of, sician and burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 the as nding IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by KIDNEY END STAGE DISLASE Records, The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death?

1 Yes 2 No Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify မ 1 🔽 Inpatient 2 🗌 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury death. Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🔲 To the only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 00064986 7/12/12 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) **JUL 1 6 2012** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month - 04Day - 2012 06:10 AM JACQUELINE BUTLER-FREEMAN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Mir Director 578-76-2714 56 1 M 2 XF 02-23-1956 WASHINGTON, DC or 28a-f show notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Tyres 2 No PRINCE GEORGE'S SUITLAND 10e. Street and Number 'n 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral 23a 5407 MORRIS AVENUE 20746 U.S.A. ral", or items 2 Examiner mus death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 Divorced 4 Divorced Specify: BLACK Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) THE BRICKSKELLER INN 11TH GRADE RECEPTIONIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ EDWARD BUTLER DELORES INEZ BATTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MANETT N. BUTLER - DAUGHTER 2228 ALICE AVE. #304 OXON HILL, MD 20745 20a. Method of Disposition
1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ö cemetery, crematory or other place) Department of Important: If any injury or once. 4 Donation 5 Other (Specify) HARMONY MEMORIAL PARK 07-16-2012 LANDOVER, MD 22. Name and Address of Facility  $\overrightarrow{PINCKNEY}$ -SPANGLER F. H. of Funeral Service Licensee 524 - 8TH STREET. N. E. WASHINGTON, DC 20002 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Norasuleivic COIDAN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, burial-transi death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). attending physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏋 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed' certificate I 1 Yes 2 🗌 No Yes 2 V N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 TNO After this c tuneral dir 2 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending 1 Yes Accident Suicide 2 No Investigation 6 Could not be

P.O. Division of Vital Records,

within 24 hours after death

To the Funeral Director: /
completely filled in by the 1 To the Hospital

State

Medical

ERIC McDONALD 31. Date filed (Month, Day, Year) JUL 1 6 2012

29b. Signature and title of certifier

29a. Certifier

(Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

7503 SURRATTS ROAD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

071131

29d. Date signed (Month, Day, Year)

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

CLINTON, MD 20735

D 64055

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ CASTILLO 2212 Medical 4c. County of Death
Montgomery 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bethesda Suburban Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 578-76-5102 73 Director 1 M 2 XF 1/25/1939 Spain Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland aţ Director "natural", or items 23a or 28a-f sl idical Examiner must be notified MD Silver Spring 1 🗆 Yes 2 🕇 No Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20906 USA 3829 Ferrara Drive Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☑ Yes 2 ☐ No Specify: Spaniard Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White Specify: 3 🛚 Widowed 4 🗆 Divorced Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Cosmotologist Beauty Salon Be 18. Mother's Name (First, Middle, Maiden Surname)
Valentina Aranda Valdelvira 17. Father's Name (First, Middle, Last) ္ပ Juan Puerto Ruiz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3829 Ferrara Drive Silver Spring, Md. 20906 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Juana Puerto Sandy/sister 20b. Place of Disposition (Name of cametery, crematory or other place)
Chesapeake Crem. 7/17/2012 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Beltsville, Md 4 Donation 5 Other (Specify) Funeral Service Licens PATETE ADERTINALDI FUNERAL SERVICE, P.A. 241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death MUTIPLE MY GLOMA Immediate Cause (Final Physician/ disease or condition resulting in death) 6 years Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter I denying Examiner Due to (or as a consequence of): as the burial-transit Cause (Disease or injury attending physician and for use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month 1 Yes 2 9 Unknown has been signed by the a ge 2 should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown CONGESTIVE HEART FIN WILL 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform death? 1 Ves 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: ပ Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 25a) (Type, Print)

17

Angel Romero Carreto State of Maryland / Department of Health and Mental Hygiene 2012 24283 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 11, 2012 2307 hrs Medical Examiner Angel Romero Carreto 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Center Bethesda 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director none 33 9/28/1978 1 3 M Gcoantemala 2 F Usual Residence of Decedent 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 X No or 28a-f show the Medical Examiner must be notified at once. imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

satt. If item 27 is marked other than "natural", or items 23a or 28s-f sho we other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 8810 Lanier Drive #102 20910 Guatemala Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14 Race - American Indian Black 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Guatemalan White Yes If Yes, Give Year or Dates: 4 Divorced 1 X Yes 2 No specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction 18 Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Nazario Pantaleon Romero Aguilon Maria Dolores Carreto Perez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod2091019a. Informant's Name/Relationship (Type, Print ) 2 Santos Romero Carreto/Bro. 8810 Lanier Drive #102 Silver Spring, Md | 20c. Location - City or Town, State | 20c Loca 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, permit. Pages 1 and crematory or other place) Municipal Cemetery 1 X Burial 2 Cremation 3 X Removal from State 7/21/201 aportant: Donation 5 Other Sp 5 PHILE POR PARTIE PARTIE P.A. 9241 Columbia Blvd.Silver Spring, Md2091 21. Signature of Funeral Service L Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a, Part I. En **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last DIVISION OF VICAL INCOMES, .... Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED the attending physician ed for use as the burial -AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown detached signed by the 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ě 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available certificate has been autopsy prior to completion of cause of death? performed? 1 🗸 Yes Yes 2 No 2 No 25 Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other. this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) Unknown 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural Pedestrian struck by auto Division Unknown Pending 1 Yes 2 V No n 24 hours after death. the 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Inner loop 495 btw exits 30 & 31, , MD determined (Specify) Major Road / Highway Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the ] 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. July 12, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Pamela E. Southall, MD 2. Registrar's Sign State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 Physician/ 2012 0409 ROBERT ELMER COLLINS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Cumberland Western MD Regional Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 □ F Hours 08/09/1941 Country) 234-62-4303 70 Director Maryland Usual Residence of Deceden or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State Examiner must be notified at Director 1X Yes 2 ☐ No Ridgeley Mineral 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 26753 62 Blocker Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11, Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates. th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TOMAR Trucking Co. Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elva Growden ပ Daniel Elmer Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 659, Ridgeley, WV Shirley M. Collins / Wife Department of Health Important: If item 27 any injury or other the 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 X Cremation 3 Removal from State Cumberland Crematory | 07/05/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. i. i. n Medical ASYSTOLE disease or condition resulting in death) Due to (or as a consequence of) Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, Due to (or as a some quence of if any, leading to immediate cause, Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

The Funeral Director; After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1. Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident ☐ Accider☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 06/30/2012 GOPE, MID D72287

16 t

CHARLES H. MOORE,

State
Registrar

M.D., 12500 WILLOWBROOK RD, CUMBERLAND, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 9, Marcella Cioni 2012 9:39 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 601 Frederick Street Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-48-9203 09/20/1920 **Director** Maryland 1 □ M 2 💢 F ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Allegany Cumberland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21502 601 Frederick Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ρ 1 Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Virginia ပ Brennan Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 601 Frederick Street, Cumberland, MD 21502 Thomas J. Cioni / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of P Important; If ite any injury or ot once, cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 07/10/2012 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in the art failure. List only one cause on each line. 404 Decatur Street, Cumberland, MD Approximate Interval Between Onset and Death Physician/ 712) Medical resulting in death) **Examiner** HTEKINSCHULD TIC Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buris Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CEREBROUMCULAR disense 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD

32. Registrar's Signature

D42054

July 9, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First. Middle, Last) 2. Date of Death  $J_{11}^{Month}$ 2012 Year Physician/ 11 10:25 Pearl Rosalie Crandell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Hours Director 219-30-3029 1 □ M 2 🗓 F 81 04/29/1931 Maryland Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No Lothian MD Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be n Funeral **USA** 5811 Crandell Road 20711 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bank Teller 12 Banking and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eugene Preston Griffith Ella Estelle Catterton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce, Deborah Crandell Whetzel, daughter 5800 Crandell Road, Lothian, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 7/12/2012 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Illian RG M00715 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 After this certificate 1 Yes 2 No 25. Was case referred to medical Be Other: 1 Yes 2 V No မ 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending leral Director: Af 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examination: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) 111(15 30. Name and address of per completed cause of death (Item 23a) (Type, Print) dRW 12 VIK 210 BAR BOLLS MO 21401 013 5 70 SOM 31. Date filed (Month, Day, 32. Registra Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Garabed 2:08 am Ju<sub>1</sub>y Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery 3532 Dartmoor Lane 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours (Month, Day, Year) 220-88-9944 Director 1 □ M 2 🏝 F 57 July 28, 1954 Syria permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Examinar must be natified at any Injury or other traumatic event, the Medical Examinar must be natified at 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔣 No MD 01ney Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 USA 3532 Dartmoor Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2 🖾 No If Yes, Give Š 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 4 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Tailoring Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arshalous Nazarian Nerses Tanashian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3532 Dartmoor Lane, Olney, MD 20832 Nerses Garabed/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 14, cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part Eter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Final etastano Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) 24ens Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and Completely filled in by the funeral director, page 2 should be detached for use es the burial transit. nding physicien and use es the buria transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No.
9 Unknowh Ectopic pregnancy Day 5 Other (specify) Pregnant at time of death q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 Tes 2 🖸 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

Michael J. Pishvaian, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

DC 20007

(Lombardi Cancer Center)

3800 Reservoir Road, NW, Washington,

20)2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 6:52A. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MITY 10 Day 2019 ar Physician/ Victor Chirieleison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hillhaven Assisted Lvg. Nursing & Rehab Ctr. Adelphi 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours Min Feb. 8, 1914 1 🛛 M 2 🗆 F 98 Washington, DC 577-05-6985 **Director** Usual Residence of Decedent 10d. Inside City Limits or items 23a or 28a-f shov 10c. City, Town or Location 10h County and 2 should be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Kensington Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20895 3922 Dunnel Lane 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Foreign Service Officer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carmela Brigulio Giacomo Chirieleison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Brandywine 4545 Connecticut Ave.,#530 N.W. Washington,DC20008 item 27 Michel Chirieleison -daughter other. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 7/19/2012 Suitland, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Bonald Words Borg Wardt Funeral Home, PA Donal 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) use as the burial Physician/Medical signed by the attending physiciar Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ğ Month Day Year detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by þe orkinson's 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 performed? Yes 2 2 No ☐ Yes 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? injury Natural 5 Pending after death. Director: Af 2 🗌 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) upleted filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 ∐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) . Signat 47867 completed cause of death (Item 23a) (Type, Print) nd address of pers Rd # 216. Rockille MD 20852 4701 Rando

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1 Decedent's Name (First Middle Last) Month Year **Physician** 7:20 PM Jul 2 2012 lancia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cristield Somerset lawes Nursing Home If Under 1 Year | If Under 24 Hrs. | Hours | Min. 8. Date of Birth (Month, Day, Year)

Jan. 8, 1918 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕶 F Months 212-14-4543 94 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Cristield Somerset Be Completed by Funeral Director Maryland 10g. Citizen of What Country? 10e. Street and Number .S. A. 21817 Chesapeake Ave 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 ₩Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pauls 11th grade aborev 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Collins Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernel Cottman - son Cristicald Chesapeake ave, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of I
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/12 4 ☐ Donation 5 ☐ Other (Specify) Cemeter 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Anthony E. Ward Ave Princess Anne MD, 21853 Hampden 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. a□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by Dementia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \( \square\) No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 ☐ Pending investigation (Month, Day Year) Injury To the Funeral Director: After the Funeral Director: After To the Funeral Director: After the funeral M 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hall Higheray, Crifield MD 21817 Kaymburattan Vyay

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar Signature

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Collins Lamont Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death REGIONAL HICOMICO 514/5/14/4 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** - 9850 38 (Month, Day, Year) 1 XM 2 □ F Director Maryland NOV. 27 mit. Page 1 and 2 should be filad within 72 hours aftar daath with the Maryland partment of Haalth and Mantel Hygiana. Sortent: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examinational be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cristield 1 Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 303 21817 U.S.A. Somers Cove Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 ♣No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sherwin Williams 12 th grade Labores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Washing ton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Douglas-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

M+, Pee- Cemete. 20c. Location - City or Town, State permit. Page 1 a
Department of I
Importent: If ite
eny Injury or ot 1 Burial 2 Cremation 3 Removal from State 21/12 4 ☐ Donation 5 ☐ Other (Specify) Marion Station Md 21. Signature of Puneral Service Licensee Ward F. H. Anthony 22. Name and Address of Facility 30639 Ave. Princess Anne, MU, 2185 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): baan signed by tha attanding physician and should ba dateched for use as tha buriel-trensit The law raquires that tha daath certificata be axecuted Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , paga 2 has autopsy performed? Yes 2 No hours aftar death. Ineral Director: Aftar this certificata I ly filled in by tha funeral diractor, pag 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this certifica complataly filled in by the funeral director, I 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥, 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier dim 047094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.47ESAN S. DIVISION sheet squis BUPY 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2:37 a 017 991120 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death toppital More 8. Date of Birth (Month, Day, If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Mir Year) 1 □ M 2 🔀 F 5 3/15/2007 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🔀 No Maryland Harford Forest Hill 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21050 245 Melrose Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 1 X Yes 2 □ No Specify: Mexican Specify: Hispanic 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Kevin Caggino Jennifer Marie-Aguirre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 245 Melrose Court, Forest Hill, Maryland Vincent Caggino (father) 20c. Location - City or Town, State West Chester, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place RA Ferris & Co. 7/5/2012 Pennsylvania 22. Name and Address of Facility Zellman Funeral Home, P.A. S.Washington St. Havre de Grace. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Frysician Medical Examiner

Physician/

Medical

Director

Funeral

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Completed

Be

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**Examiner** 

**Funeral** 

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

the burial-trar as within 24 hours after deat To the Funeral Director:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

0	Immediate Cause (Final disease or condition resulting in death)	Cardiorespiratory failure Due to (or as a consequence):		Onset and Death						
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
ted by PI	Part II. Other significant conditions cont	ributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes	use contribute to the cause of death?						
Completed			24a. Was an autopsy performed?							
õ	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)							
0 0	1 Yes 2 No	spital:    Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Hon	ne 5 Residence	6 Other (Specify)						
ertificate: (	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	ury occurred								
٥	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)						
Medical	(Check 2 Medical Examine	inan: To the best of my knowledge, death occurred at the time, date and place, and r. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place.	the time, date and place	ce, and due to the cause(s) and manner stated.						

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

completely

Name and address Vichael

of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 907 H Royal St. Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye May 2 1 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 212-24-8503 Director 1 ☐ M 2 F 1925 Maryland 87 May or than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Anne Arundel Maryland **Annapolis** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 907 H Royal St. 21401 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3X Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Admiral Cleaners 11th Presser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental H James H. Chambers Sr Blanche E. Johnson and 2 should b Health and Mer tem 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 820 Seal Harbour Pasadena, Md. 21122 Gregory Cully(Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran permit. Page 1 a
Department of H
Important: If ite
any Injury or oth 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 7-12-12 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Winner Reverse of Secilisions Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or injury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy After this certificate 1 Yes 2 No ☐ Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 XNO 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. 2 Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 12

State Registrar

P. 0.

30. Name and address of person who completed cause of death (tem 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 325M <del>2</del>012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death REGIONAL Medical HICOMICO PENINSULA Coste 546156414 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) 218-34-8335 1**5** M 2 □ F **Director** March Mariland 27 is merked other then "naturel", or items 23e or 28e-f ehow traumetic event, it e Medical Examinar mint be positied at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Princess 1 **Y** Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Pine Knoll 30589 21853 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1 Yes 2 No Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Black 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) end Mentel Hygiene. Is merked other then Elementary/Secondary (0-12) College (1-4 or 5+) Security Guerd Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mervin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 rincess Anne, Christ Dr. MD. 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Department of Importent: If eny injury or once. Princess Anne MD 4 ☐ Donation 5 ☐ Other (Specify) Wesley Cemetery 114/12 21. Signature of Funeral Service Licensee Ha moden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysiciani disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospitel or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.
To the Funerel Director. After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Anpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 
Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>012</u> Physician/ July 11 0435  $A^{M}$ Laura Bertha Hemphill Clark Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly Social Security Number 7. Age (In yrs. last birthday) \_lf\_Under 1 If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) **Director** 242-48-2941 1 M 2 X F 76 1936 North Carolina 28a-f show 10b. County death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Bowie Maryland | Prince George's ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 20718 United States 2703 Lode Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ☐ Yes 2 🔀 No Yes, Give 21215-0036 1 Yes 2 X No Specify: **Black** 3 Divorced Specify: Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)
5+ Government Educator Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Woodward Hemphill Evangeline Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. McCullough - Husband 2703 Lode Street Bowie, Maryland Department of Health Important: If item 27 any injury or other trong once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lee's Crematory 2012 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Teneut M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ HEPATOCELLUL CALCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any fracing to immediate cause. Enter Underlying Cause (Disease or injury Due to jor as a consequence of -tran and that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the 9 Unknown Unknown s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL DISEASE Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has filled in by the funeral director, page 2 autopsy performe 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 **N**No examiner? Hospital Other: 1 Tes 1 Nnpatient 2 ER/Outpatient 3 DOA 읻 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director; After this 27. Manger of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE CHEVERLY MD 20185 MD 3001 D. GREEN

DHMH 17 Rev 06-2011

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $J_{u1y}^{ ext{Month}}$ Elizabeth Tomlinson Corson 201<sup>Yea</sup> 01:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Homewood at Williamsport <u>Williamsport</u> Washington Social Security Number If Unde Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 M 2 T Months Min. (Month, Day, Year 414-07-4098 Director 92 Tennessee July Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location items 23a or 28a-f sho er must be notified at 10a. State 10d, Inside City Limits Director MD Washington Williamsport 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 16505 Virginia Avenue 21795 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. the Medical Examiner Armed Forces Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married ō Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill flealth and Mental item 27 is marked other traumatic eve ဂ္ဂ John Jordan Tomlinson Sr. Cora Ellen Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Corson Jr./Son PO Box 12793. Lahaina, Hawaii 96761 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 07/28/2012 Mount Olivet Frederick, MD 22. Name and Address of Facility Keeney & Basford Funeral 21. Signature of Funeral Service Licenses M01646 Home. 106 E. Church St. Frederick, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e ich line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year ed by the 1 ☐ Yes 2 ☐ 9 ☐ Unknown ate has been signed by page 2 should be detact ditions contributing to death but not resulting in the uncerlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page ☐ Yes 2☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manyer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 \(\sime\) Yes 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Dav

3 0 2012

2 M

DHMH 17 Rev 1/2001

Amended #26 "Daughter's Home," per verbal, phy., 07/05/12, nls, AC
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #26, nls, per phy., 07/05/12, Allegany Co. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ June 29, 2012 04:00 PM William George Duncan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Frostburg 118 Victoria Lane If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year)
June 14, 1926 Days Hours Min 1 **X** M 2 □ F Director 86 Maryland 212-24-0111 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1X Yes 2 ☐ No Frostburg Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Braddock St. Completed by Funeral U.S.A 21532-**Unit 305** 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Year or Dates. WWII 3  $\square$  Widowed 4  $\square$  Divorced permit. Page 1 and 2 should be filed within 72 hours bepartment of Health and Nental Hygeles. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is any injury or other traumatic event, the Medical Is 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Financial Institution Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Emma Meagher Walter Duncan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Maryland Wife 100 Braddock Street Frostburg Anna Duncan 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 

■ Burial 2 

□ Cremation 3 

□ Removal from State Maryland Frostburg Memorial Park July 03, 2012 Frostburg 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service License Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE disease or condition Medical resulting in death) Examiner CORONARY Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequend of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and g physician and as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page 2 2 🔲 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: Paughter's 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 3 ☐ Residence 6 ☑ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral 1 Natural 2 Accident 5 Pending injury 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar Hidlen

Harjit Sidhu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 Bishop Walsh Rd.

026907

Cumberland, MD 21502

2-05174		Ple	ease Typ	e or l	Print in Bl	ack In	delit	ole ink. I	Ensu	re All C	opies	Are Leç	gible	€.	
Duston Mathew D	etri	ck	St	ate of	Maryland	/ Depa	rtme	nt of Hea	alth ar	nd Ment	tal Hygi	ene			
	-	- For State				Cen	tifica	te of Dea	ath			Re	g. No.	201	2 2429
Physiciar		Registrar 1. Decedent's Nam	e (First, Midd	e,Last)							2. 1	Date of Deat	_		3. Time of Death
Medical Examin		Dust	on		Mathe	TaT		Detri	rk			Month uly 9, 201	Day 12	Year	1908 hrs
		4a. Facility Name (		n give str			_			or Location o		diy 0, 20		. County of Dea	th
	ш	Burton Park				,			vlings				- 1	llegany	
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Funeral		5. Social Security N	Number	6. Sex		je (In yrs. la	st birth	Mon	nder 1 Ye		Min			Fore	irthplace (State or ign Many Land
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Ment de coc		19a. Informant's Na	ame/Relations	hip (Type.	Print )		19b.	Mailing Addre	ss (Stre	et and Num	ber or Rura	l Route Núm	ber, C	ity or Town, Stat	e, Zip Code)
shou shou	^[	Rose A.						2220 Li	,				,		
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. trem 27 is marked other than "natural", or items 23a or 28a-f sho trem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	H	20a. Method of Dis				Zoh D		Disposition (N				ate		Location - City of	
Slan ffe ffic		1 X Burial 2	<u>.                                    </u>	3 🗆 1	Removal from St	ate c	remato	ry or other plac	ce)					-	
More Pages 1 ent of H int: If i			Other S			P1	eas	ant Gro	ove (	Cem.	07/13	/2012	(	Cumberla	and, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	k	21 Signature of Fu						22. Name ar	nd Addres	ss of Facility	, Adam	s Fami	ily	Funera	1 Home, P.A.
Balt permit. Departi Import	- 1	UNA NOIC	K (10	$\infty \Omega k$	4			404 De	ecati	ır Str	eet,	Cumber	clai	nd, MD	21502
Physician	+	23a, Part I. Enter th	ne disease, or	complicat	ions that caused	the death.	Do not	enter the mode	e of dying	g, such as ca	ardiac or res	spiratory arre	st, sho	ock, or heart	Approximate Interval
Wedicar	1	failure. List on		on each l	ine.										Between Onset and Death
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Box 68760, e death certificate be the attending physic ed for use as the burner.		IF FEMALE: 23b. Was decedent	pregnant in the		3c. If yes, outco	me of pregr		Fatal dans	th 3	Ectopic	pregnancy		230	<ul> <li>d. Date of delive</li> <li>Month</li> </ul>	ry Day Year
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lox 6 leath cert e attendir	응	1 Yes 2	No 9 Un	leanning 1	Unknown		atri 5	Other (Sp	ресіту)				1		
he de	計	Part II. Other sign	ificant condit		ntributing to deat	h hut not ro	culting	in the underhei	00.000.00	givon in Pa	art I	23e Did to	hacco	use contribute to	the cause of death?
Division of Vital Records, P.O. B to or Attending Physician: The law requires that the d is after death.  In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	2	rait ii. Outer sign	meant condi	iona co	ithibuting to deal	ii but not re	suiting	iii die didenyi	ng cause	giverinita	41.				bably 4 Unknown
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Vital Recysician: The linis certificate director, page	e R	25. Was case refer examiner?	rred to medica		ital:					oe of Death					
this by Sic	0	1 🗸 Yes	2 No	Hosp	oital: 1 Inpati	ent 2	ER/Out	patient 3	DOA		Nursing H			ence 6 🗹 Oth	
ing Pl		27. Manner of Dea	th		28a. Date of Inj (Month, Day,) FOUND:	ury Year)		me of Injury	1 _	jury at Work	IOn	d. Describe h	now inju	ury occurred TN	IVOLVED led in collision
the fr.	Certification:	1 Natural	5 Pen		Jul 9, 2012		FOU! 1900		1	Yes 2	No Op	CIGIOI OI	111010	TOYOIC INVOV	ica iii combion
rect de	[일	2 Accident 3 Suicide		stigation Id not be	28e. Place of I	njury - At ho			ory, office	building, et	c. 28f			nd Number or F	ural Route Number, City
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hou hou ly fill		4 Homicide 29a. Certifier	0-464 D	h l - l				b a a a surre el a t t	lho timo	data and nic					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring.	S	(Check only 1 one) 2			To the best of m the basis of exa										
To the complete compl	Medical		1	an	d manner stated		0. 111					-, 3010			
17	Σ	29b. Signature and	title of certific	er				2		nse number					onth, Day, Year)
4		llu	200						0.0	.M.E.			July	10, 2012	
	ŀ	30. Name and add	ress of persor	who com	pleted cause of	death (Item	23a)				-				
Not 8		Ana Rubio			sistant Medi	cal Exan	niner	900 W. B	Baltimo	re Street,	Baltimo	e, MD 21	223		
		31. Date filed (Mon			32. Registra	ar's Signatu	re/								
Sta	(6	11 11	itri, Day Year)	) /	) La registi	Agriatu	bar	Les .							

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			For Stata Registrar	S	tate of	Marylar		artmen			and M	ental Hy	giene	012	24299	
	Physici /Medic		1. Decedent's Name (First, Michael A. Ve Vee	dle, Last)	Dix	on						2. Date of De July		2012	3. Time of Death 5:40 Am	
	Examin		4a. Facility Name (If not institut Loch Raven Co	mmun	ity LII	ling (		Bal	timo					ounty of Death		
	Funeral Director		5. Social Security Number 428-38-7878  Usual Residence of Decedent	6. Sex <b>№</b> м		Age (In yrs.		Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 03/5/	th ly, Year) 1924	9. Birthp Cour	lace (State or Foreign htry)  MS	
	Maryland If show	tor	10a. State 10b. County 10c. City, Town or Location										1	0d. Inside City Limits		
	th with the 23a or 28a	ai Direc	10e. Street and Number 2003 Bunker	Hill	Cour	t		10f. Zip	Code 2111	13			10g. Citize	un of What Cour	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, it a Medical Exactions must be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ M. 3 ☒ Widowed 4 □ Divorc	ırned	Armed Force	ent Ever in U es? □ No 194 es: 1966	944- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							14. Race - American Indian, Black, White, etc.  Specify: Black		
21215-0036	within 72 ho ane. than "natur be Medical	mpieted	15. Deced (Specify only high Elementary/Secondary (0-12 12th	-	on <i>mpleted)</i> College (1-4	or 5+)	(Giv	edent's Usua e kind of wor DO NOT us	k done d	uring most	of workin	g		Sb. Kind of Business/Industry Military		
Maryland 2	uld be filed Mental Hygis Irked othar Itic event, II	To Be Co	17. Father's Name (First, Middle, Last)											у		
	and 2 sho saith and ! 1 27 is me er treums		Jackie Evans/Dtr. 2003 Bunker Hill (							Rural Route Number, City or Town, State, Zip Code) Ct. Odenton, MD 21113						
Baltimore,	Pages 1 ament of He ent: If item ury or oth	1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  Sand Hill State Vet. Cem. 7/20/2012 Spring									-					
Balt	permit. Departi Import any inj		21. Signature of Funeral Service	CBM		Tonce	_ 2	2294	old	Wash	ning	ton R	D Wa		ral Home MD 20601	
3760,	Physician /Medical Examiner	icai Examiner	23a. Pirt1. Enter the is use, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  Preumonia  a. Aspiration Preumonia  Due to (or as a consequence of):  Consequence of):  Due to (or as a consequence of):													
.O. Box 68	The law requires that the death certification has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown								23	23d. Date of delivery  Month Day Year				
s, D	quires that in signed by	by	Part II. Other significant cond	tions contrib	uting to dea	th but not res	ulting in the	underlying ca	ause give	n in Part I.				cco use contribute to the cause of death?		
al Record	: The law requir cate has been si page 2 should	Completed												prior to cor death?	psy findings available inpletion of cause of 2 No	
Division of Vital	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to mediexaminer? 1 Yes 2 No 27. Many r of Death 1 Natural 5 Peninger	Hosp 2	1 ∐∃np 8a. Date of		ER/Outpatie 28b. Time Injury	_	Bc. Injury Work	r: 4 □ Nui	rsing Hom	(Check only one 5 Resident Res	dence 6	ther (Specify	, Kospice	
Divis	tel or Attencts after death	Certification:	3 Suicide 6 Could not be a letermined 28e. Place of Injury - At home, farm, s building, etc. (Specify)					treet, factory	, office		2	8f. Location (: City or To		et and Number or Rural Route Number, State)		
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai	29a. Certifier 1 Certify (Check only one)	ring Physicia al Examiner:	n: To the b On the bas and manne	is of examina	wledge, dea ition and/or i	th occurred anvestigation,	at the time in my op	e, date and inion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) ar date and p	nd manner as st lace, and due to	ated. the cause(s)	
)	To the within 2 To the complet	Σ	29b. Signature and title of certification of the second se	2. V	liele	M	M.D.		License ) 41	365	5	0	Jul	signed (Month,	2012	
	BO ×1		30. Name and address of person			of death (Iter		, Print)	390	Balt	och	raye	avxl	and	21218	
	Sta Registr		31. Date filed (Month, Day, Ye.	6 2012	32. 1969	istrar's Signa	A. A	back	/							

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nigno Pereyra		ran 1- For State Registrar	State of Ma	aryland i	•	nent of cate of			Mental	Hygi		Reg. No.	20	12	243
Physicia	n/	1. Decedent's Name (First, M Benigno	<sup>iddle,Last)</sup> Pereyr	a	Duran					- 1 1	Date of De	Day	Year		me of Death 324 hrs
edical Examir		4a. Facility Name (if not instit				4	b. City, To	wn, or Lo	cation of D		uly 6, 20		c. County of Dea		
-1		Calvert Memorial H					Prince	Freder	rick			(	Calvert		
Funeral Director		5. Social Security Number N/A	6. Sex		e (In yrs. last b	oirthday) Yrs.	If Under Months		If Under 2 Hours	4Hrs. 8 Min.	. Date of B	`	(DD/YYYY) 9. B Fore 050	ian	Mexico
ķ		Usual Residence of Deceder 10a. State 10b. Cou			10c. City, Tov	vn or Locatio	on							10d.	Inside City Limits
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arylan 8a-f sl at onc	Director	10e. Street and Number	2100 22 11	110			10f. Zip (	Code		_		10g. Cit	izen of What Co	untry?	
the M a or 2 tiffed		Ave. Juan Mar	nuel Rey	es 35	NTE		35	168					Mexico		
Baltimore, MD 21215-0036  pennit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 X 2		as Decedent med Forces? Yes 2		If Ye	es, specify	Cuban, N	nic Origin? Mexican, Pu	uerto Ric	an, etc.)	0-	14. Race - Ame White, etc.		
after d al", or	Dy F		Divorced If Yes, Cor Date	Sive Year					specify:					spa	
hours	B	15. Decedent's Education (				<ul> <li>a. Decedent during mo</li> </ul>	's Usual C ost of work	ccupation ing life. D	n (Give kind O NOT use	d of work e retired)	done	16b.	Kind of Business	s/Indust	ry
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5-0036 led within 7 Hygiene. I other than	흥	17. Father's Name (First, Mic		-				18		•		Maider	Surname)		
21215 ould be file I Mental H is marked ic event, t	8		ereyra						Magd			ura			<del></del>
D 2.	의	19a. Informant's Name/Relat Maria G. Gonz											city or Town, Sta ary1and		<sup>Code)</sup> 1735
and 2 sho ealth and tem 27 is traumati	-	20a. Method of Disposition		- Daugne	20b. Plac	e of Disposi	tion (Nam				ate	·	Location - City of		
Baltimore, permit. Pages I an Department of Hea Important: If iter		1 Burial 2 XXCrema		noval from St	ale	natory or oth a.s. Cre		rv		07/1	0/201	1	Edgewate	r.	Maryland
altin nit. Pa artmei oortan	1	4 Donation 5 Other 21. Signature of Funeral Ser			11021			-					as Funer		
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Physician /Medical		23a. Part I. Enter the disease failure. List only one ca	use on each line.							liac or re	spiratory a	rrest, sh	ock, or heart		proximate Interval etween Onset and
Examiner		Immediate Cause (Final dise or condition resulting in deat		rtensive A	therosclero	tic Cardi	ovascul	ar Dise	ase					+	Death
		Sequentially list conditions,	b.	(Or as a cons	equence or).										
	iner	if any, leading to immediate cause. Enter Underlying Ca		(or as a cons	equence of):										
=	Examiner	(Disease or injury that initiat events resulting in death) L	ed C.	(or as a cons	equence of):									+	
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50, te be executed sysician and burial - transit	edical	UNPENDED		NDED			-		_				2d Date of dollar		
Records, P.O. Box 6876( The law requires that the death certificate care has been signed by the attending phy-	Physician/M	IF FEMALE: ?3b. Was decedent pregnant past 12 months?		Live birth	me of pregnan		al death	3	Ectopic pr	regnancy	,	23	3d. Date of delive Month	Day	Year
or use	sicia	1 Yes 2 No 9	Unknown 9	Pregnant at	t time of	5 Oth	ner (Spec	ify)							
D. B. the de by the ched f	Phy	Part II. Other significant co		Unknown outing to deat	th but not resul	Iting in the u	nderlying	cause giv	en in Part I	l.	23e. Did	tobacco	use contribute t	to the c	ause of death?
P.C es that igned	d by										1Y	es 2	No 3 Pr	obably	4 🗸 Unknown
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eco he law ate has age 2 s	dmo									_		formed?		Yes	2 No
of Vital Records, P.O. ng Physician: The law requires that the Witer this certificate has been signed by meral director, page 2 should be detach	Be C	25. Was case referred to me examiner?					2		f Death (Cl	heck only	one)		Land		
F Vit Physic or this or	<b>To E</b>	1 ✓ Yes 2 No	Hospital	i iiipatii	ent 2 🗸 EF					lursing H		_	ence 6 Oth	ner:	<u>.</u>
_ = -	ion:	27. Manner of Death  1  Natural 5	Pending	a. Date of Inj (Month, Day,)	Year)	b. Time of Ir	ijury 2		at Work?	i	d. Describe	e now in	jury occurred		
Division tal or Attendii rs after death. al Director: A	icat	2 Accident	Investigation	Be. Place of Ir	njury - At home	e, farm, stree	et, factory,				f. Location	(Street	and Number or I	Rural R	oute Number, City
Div	Certification:	Odivido	Could not be determined (5	Specify)							or Town,	State)			
e Hosp 124 ho e Func etely f	25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Wanner of Death  28. Describe how injury occurred  28. De										(.)				
To the within To the compl	Set to the course of the cours														
~ 1	29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo)  O.C.M.E.  July 7, 2012								norith, L	Jay, rear)					
26		30. Name and address of pe	rson who comple	ted cause of	death (Item 23	(a)		J.J.,VI					-, -,		
,			Deputy Chief				Baltimor	e Stree	et, Baltim	ore, M	ID 2122	3			
	ate	31. Date filed (Month, Day, Y			ar's Signature		,								
Regist		JUL	1 0 2012	Con	ma,	1. p	all			-					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 07 Physician/ Downs M auline Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL GENESIS ELDER CARE SEVERNA PARK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8/18/1927 1 □ M 2 🗓 F MARYLAND Director 84 212-42-2836 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 XNo MILLERSVILLE MARYLAND | ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral UNITED STATES 468 WATSON COURT 21108 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. Armed Force Completed by Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 2 should be filed within 72 hours after thand Mental Hygiene.
27 is marked other than "natural", traumatic event, the Medical Exal 3 X Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) COOK COOKING Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ ALBERT PARKER AGNES BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shi Department of Health an Important: If item 27 is any injury or other trau 468 WATSON COURT MILLERSVILLE, MD 21108 MARLENE JOHNSON/DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition BEST GATE MEMORIAL PARK 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ANNAPOLIS, 7/11/2012 MD4 Donation 5 Other (Specify) ne and Address of Facilit LASTING TRIBUTES BY FELLOWS ENBEIN & NEWNAM CREMATION & FUNERAL CARE BESTGATE ROAD ANNAPOLIS, MD 21401 21. Signature of Funeral Service Lice nt 1. Enter the digness, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Cerebral Vascula Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for u in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death?
1 ☐ Yes 2 ☐ No 2 1 Yes I or Attending Physician: after death.
Director: After this certifications completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 \square Yes 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident
Suicide 2 🗌 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 07/06/2012 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

State Registrar Na

Diama 31. Date filed (Month

egistrar's Signature

wite B glen Burnie, MP 2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Wic 0 mic 8. Date of Birth (Month, Day, Year) If Under 9. Birthplace (State or Foreign **Funeral** Months Hours 9188 Director 1 M 2 - F 70 MAYYIAND ed other then "neture!", or items 23e or 28e-f show event, the Madical Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 Yes 2 No ACCOMACK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 34 1ANCE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. permit. Pege 1 and 2 should be filed within 72 hours efter. Department of Heelth end Mental Hygiene. Importent: if item 27 is marked other then "neturel", or eny injury or other treumetic event, the Merce. 1 Never Married 2 Married 1 Yes 2 No Ś 1 ☐ Yes 2 🔀 No If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Meat MEAT Mgr. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ h Spoase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POCO MOKE CITYME LI851 altimore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, OAK HAIL 4 ☐ Donation 5 ☐ Other (Specify) 7/13/2012 WNINGS FUNEVAI M6 Me 21. Signature of Funeral Service Licensee TEMP. UA 7 of LANKFAYO 23a. Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral by arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ESOPHALRAL MRTASTATIC disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours efter deeth.

To the Funerel Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burlel-trensit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 盎 26. Place of Death (Check only one) HOSPICR Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural
2 Accident 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUMAN WARY 6 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30.per DVR, 2929 7-13-12 sm State of Maryland / Department of Health and Mental Hygiene AMEND #25, PER MD G929 7/31/20 TRETate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July .Day 2012 Year **Physician** 3, 3:35 P Joseph Dolan Evans /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Forest Hill 404 E. Jarrettsville Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) **Funeral** Days Hours Min Months 1 ₹ M 2 □ F 77 Yrs. 212-32-0035 8/26/ 1934 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant be notified at Forest Hill Harford 1 ☐Yes 2☐No MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21050 404 E. Jarrettsville Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Types 2 No
If Yes, Give 1959-63
Year or Dates! 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Utility Cable Splicer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Corrinne Jones Peter Dolan Evans ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 1 0 5 0 19a. Informant's Name/Relationship (Type. Print) Lois M. Evans/Wife 404 E. Jarrettsville Rd., Forest Hill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/7/12 Delta, PA Slate Ridge Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Lice Harkins F.H.Inc., Delta, PA 17314 - Hobert denno 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐Yes 2 ☑No certificate 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ funeral 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and the of c 29c. License number 264 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 510 Upper Chesapeake Drive Ste: 409 Bel Air, MD, 21014 Venkata Parsa 31. Date filed (Month, Day, 32. Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

Beneva

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TUN 10:08a M Wallace Newton Edmonds, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Plato Civista Conter La If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**X**□ M 2 □ F Months Hours Min. 09-29-194 Washington D.C. Director 213-46-9467 64 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State Director Examiner must be notified 1 🗆 Yes 2 😾 No Maryland Charles White Plains 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral United States 10410 Smitty Way 20695 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔯 No Specify: Completed 3 X Widowed 4 □ Divorced White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpentry Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lois Edmonds Wallace N. Edmonds, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12284 Kings Highway King George, Virginia 22485 Amanda Shriver/Daughter dimonds 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 07-13-2012 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. M00945 211 St. Mary's Ave. Box 567 La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical (or as a consequence of): **Examiner** Pheumania Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and -transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death been signed by the should be detached Linknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy 1 Yes 2 No certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 X No Other: 1 🗌 Yes ည 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 24 hours after death.

Funeral Director: After thi leted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier 🗸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29h title of certifie 29c. License number 29d Date signed (Month, Day, Year) 11,2012 072036 Powell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rebecca Kwell Ave Plata 20646 Crawett MO Day, Year) L 13 2012 Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Margaret Anne Esham July 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6170 Oxbridge Drive Salisbury Wicomico If Under 1 Year If Under 24 Hrs. Social Security Numbe Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours Director 220-12-1160
Usual Residence of Decedent 1 🗆 M 2 😿 F 06/06/1925 Maryland ?7 is marked other then "natural", or items 23a or 28e-f show traumetic event, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6170 Oxbridge Drive 21804 USA 12. Was Decedent Ever în U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 k No Specify: Completed 3 ₩ Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file ည John T. Lemon Maggie Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) end 2 s Health tem 27 l Suzanne McKee/Daughter 7922 Boyston Bend, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 of Pepertment of Pepertment of Pepertment: If its eny Injury or of pages. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/12 2012 Parsons Cemetery Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physicien: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the ettending physician and the for use es the burial-trans Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month cate has been signed by the cage 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospitel or Attending Physicien: The within 24 hours after death.
To the Funerel Director: After this certificate I completely filled in by the funeral director, pag Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person eath (Item 23a) (Type, Print ain 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a, b, pt. 11per doc, 15-17 per fh g931 9-21-12 vt

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:30 PM <sup>™</sup>Jul 17, 2012 **Elliott** Lorring Harvey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany LaVale 45 LaVale Blvd. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth Birthplace (State or Foreign Country) Funeral Hours Min. Jut 26, 1918 214-05-6967 1 × M 2 □ F **Director** 93 28a-f show 10c. City, Town or Location LaVale 10b. Count 10d. Inside City Limits should be filed within 72 hours after death with the Maryland be notified at Director MD Allegany 1 Yes 2 No 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 45 LaVale Blvd. 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify: "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 2 No WWII Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 white 3 → Widowed 4 □ Divorced Specify: Year or Dates event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT resenting!) A . R . C. 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government Agent -**Budget Director** Be 18. Mother's Name (First, Middle, Maiden Surname)
Lucy Mae Bowers 17. Father's Name (First, Middle, Last) ၉ Harvey Elliott William Harvey Elliott 19a. Informant's Name/Relationship (Type, Print)
Rosalind McAllister Important: If item 27 is m any injury or other traum once. Mailing Address (Street and Number or Flural Pouts Number, City or Town State, Zip (NY) 11415 8015 Grenfell St Apt. E11 Kew Gardens (NY) 11415 daughter permit. Page 1 and 2 to Department of Health 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date National Memorial Park 7/21/2012 VA Falls Church 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service Signa censee 22. Name ar Scarpelly Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease of complications that caused the useas. Shock, or heart failure. List only one cause on each line. **Vascular** complications that caused the death. Do not enter mode of dying, such as cardiac or respiratory arrest, Physician/ disease or condition resulting in death) Medical Due to (or as a con-**Examiner** Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death Other (specify) Day Year g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Aortic Stenosis 1 Yes 2 € No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Iniury 5 Pending Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

DHMH 17 Rev 06-2011

State

Registrar

Naggner

JUL 3 0 2012

. 925 Bishop Walsh Rd. Cumberland, MD 2150

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07743/2092 Alice S. Francisco 12:40р м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Days Min. Hours **Director** 526-26-8266 95 1 M 2 XF 10/29/1916 MX Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Prince George' Brandywine 1X Yes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 5110 Floral Park Road 20613 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black White etc. 2 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after y Yes 2□No Specify: Mexican If Yes, Gi Specify: Mexican Completed 3 Midowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Private Health and Mental Hygier em 27 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ysidro Solis Maria Galindo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Francisco/son 5110 Floral Park Brandywine, MD 20613 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 Kremation 3 Removal from State cemetery, crematory or other p Chesapeake Crematory 07/17/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility Briscoe-Tonic Funeral Home Buxoe Jone 2294 Old Washington Rd Waldorf, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SPIRATORY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) RONANZ burial-trar Due to for as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Į in the past 12 months? Pregnant at time of death Month Dav Year 2 No be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 | Linknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes ဂ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge 29d. Date signed (Month, Day, Year, of death (Item 23a) (Type, Print)

State Registrar SURRATTS

ROS - CLINTON

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7/7/2012 Frederick R. Fearnow 450pm M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7101 Bay Front Rd. Apt. 107 Annapolis Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 92 <sub>Yrs</sub> Months Days 375-40-7858 1 🕅 M 2 🗆 F **Director** 5/21/1920 VA Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Annapolis Anne Arundel 1 Yes XX No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 7101 Bay Front Rd. Apt. 107 21403 USA permit. Page 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

\*XX Yes 2 \sum No WWII

If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XXIo Specify White Specify. Completed 3XX Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) US Navy Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Brady Fearnow Lillie Hovermale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5861 Brookstone Way Acworth, GA 30101 Frederick C. Fearnow Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 7/10/2012 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 78 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ HEART FAILUNE disease or condition resulting in death) CONGESTIVE Medical Due to (or as a consequence of) Examiner Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) tran and Due to (or as a consequence of) the burialthe attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burner. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? F115, RENAL Completed by IN SUFFICIEN W 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Inknown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 30. Name and ompleted cause of death (Item 23a) (Type ANNOW William Dabbs, MD FARM ND. 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Fooks Lucille R. 2012 Medical 0 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death ROGIONAL TENINSULA MEDICAL 5AL 15641 HILOMICO Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days (Month, Day, Year) Director 258-42-2114 1 M 2 K F 83 Usual Residence of Deceden 08/05/1928 Arkansas show ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😿 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31106 Johnson Road 21804 **IISA** death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Black White etc. þ 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1e 1 and 2 should be filed within 75 t of Health and Mental Hygiene.
If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Owner Plant Nurserv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilbert B. Sanford Clara St. Clair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31106 Johnson Rd., Salisbury, MD 21804 Charles T. Fooks/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) wicomico Memorial Injury or permit. Page Department of Important: If 7/16/2012 Salisbury, MD Park 21. Signature of Funeral Service License 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 any Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ZUre Pnysician/ disease or condition resulting in death) ninuks Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying I hema from. Examir Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ₽ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed to should be det 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performe certificate 1 ☐ Yes 2 ☐ No ☐ Yes 2 No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificately filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Certificate: To 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 I DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☑ No 0700 M 10/12 Investigation fall 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Salisbun Medical 31106 Johnson Certifying Physician: To the best of my knowledge Medical Examiner: On the basis of examination To the Hosp within 24 hor To the Fune completely fi 29a. Certifier th occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ignorphise death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To th only one 29b. Signature and Atle of certif 9c. License number 45049 ; D59931 3TC address of person who completed cause of death (Item 23a) (Type, Print) CHRISTOPHER SNYDER; CHARLET B. HOFFMAN, 100E. CARPOLL STREET, SALISBURY, MD 21801 31. Date filed (Month, Day, Year) Registrar's Signat State 13 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 July Physician/ Ethe1 Mae Gupton 15. 5:50 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Nursing & Rehab. Clinton P.G. 5. Social Security Number . Sex . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 578-64-8687 Hours **Director** 1 M 2 🔀 F 72 Yrs March 7, 1940 NC Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 0a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? Funeral 7 Sonata Court 20901 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify Specify 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service University Of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ James Gupton Reddie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette D. McQueen/Daughter 7 Sonata Court, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park Landover, MD 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. MO1503 500 University Blvd. W., Silver Spring, 23a. Part. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preumonia Immediate Cause (Final Physiciany disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Date to for as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) be detached for in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 6 Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cognitive de fer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ity per has page 2 autopsy performed 2 No ltemocha ci C Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Accident
Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours after death. To the Funeral Director: A filled in by **N**completely

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Avenue & Swite 310 Washington DC 20032 MD State

32. Registrar's Signature

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and

3

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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29d. Date signed (Month, Day, Year)

16

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Elizabeth Gross 8:15M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown . Social Security Number Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Hours 216-30-2803 1 □ M 2 X F 84 March 17,1928 Virginia Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 1 X Yes 2 No Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21740 N. Potomac St. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. If Yes, Give 3 X Widowed 4 Divorced Specify: **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Taylor Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 N. Potomac St., Hagerstown, MD Patricia Gross/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 7/20/2012 4 Donation 5 Other (Specify) Hagerstown, MD Signature of Funeral Service 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cau Immediate Cause (Final Onset and Death disease or condition resulting in death) Menion Due to (or as a consequence of) Sequentially list conditions

Physicin Medical **Examiner** 

Physician/

Medical

Director

Funeral

Completed by

Be

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**Examiner** 

**Funeral** 

Director

23a or 28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event.

Baltimore, Maryland 21215-0036

Exami burial-tra physician Completed by Physician/Medical ed by the attending detached for use as nse ate has been signed page 2 should be de has after death.

Director: After this certificate ! To Be filled in by the funeral Certificate: within 24 hours a

To the Funeral D

completely filled Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):  d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)	23d. Date of delivery  Month Day Year				
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown				
		24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No				
25. Was case referred to medical	26. Place of Death (Che	ck only one)				
examiner? 1  Yes 2  No	Hospital: Other:	Home 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)  28b. Time of injury work?  1  Yes 2  No	28d. Describe how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and manner as stated.				

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

30. Name and address of person who

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $J_{\mathbf{u}}^{\mathsf{Month}}$ 2012 11 3:28 Abraham Garver, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Country) Director 513-44-7665 1 🛛 M 2 🗆 F 05-01-1942 70 Kansas or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. Count the Maryland Completed by Funeral Director 1 🗆 Yes 2 🙀 No Charles Benedict 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ral", or items 23a of Examiner must be . Page 1 and 2 should be filed within 72 hours after death with t ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items 23a lury or other traumatic event, the Medical Examiner must be 20612 USA 18870 Patuxent Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Auto Repair Shop Automobile Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Katie Miller Miller Abraham Garver, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 280, Deale, MD 20751 Levi T. Wellons, Employer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or of ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 7/13/2012 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD M00715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Medical Days Sepsis resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events burial-tran resulting in death) Last Due to (or as a consequence of). physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE use ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy Por in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No 9 Unknown ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed?

1 Yes 2 X No 1 🗌 Yes 2 🗆 No this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death.
Funeral Director: After this etely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🛕 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner To the best of my knowledge, death a ed at the time. Vate and plane, and drie to the within 2

To the secondless 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu July 11, 2012 D-32332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sta

Registrar
DHMH 17 Rev 06-2011

Suresh K. Gupta,

32. Registr

M.D., 9001 Georgia Ave., Ste. 220, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 8, Physician/ 2012 10:20 AM William King Goode Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Oxon Hill 507 Wilson Bridge Drive #C2 **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Min. Hours Director 577-12-7145 1 1 M 2 D F Yrs. 95 Virginia Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Oxon Hill Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral United States 20745 507 Wilson Bridge Drive #C2 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No "natural", or item ledical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian 1 Never Married 2 Married ģ Yes Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12th Bindary Unit Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) King Goode Nannie Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6807 Old Waterloo Road # 817 21075 Elkridge, Md. Mia J. Fambro - Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery Suitland, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 22 M00560 John I- Stanat 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cardio Respiratory Arrest resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of: attending physician for use as the buria Physician/Medical IF 23 the ģ Pa þ Completed

Physiciani Medical Examiner

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

requires that the death certificate be executed has certificate this within 24 hours after death.

To the Funeral Director. After t completely filled in by the funer. To the Hospital or Attending

Be ပ္

Certificate:

Medical

only one)

29b. Signature and title of certifier

Santiago Morao

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oxon Hill Road

Division of Vital Records, P.O. Box 68760

resulting in death) Last	Due to (or as a consequence of):  d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Chronic Kidney Disease  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   X No   3   Probably   4   Unknown										
Benign Prostat	e Hypertrophy	24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No								
25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 Yes 2 XNo	Hospital:  1  Inpatient 2  ER/Outpatient 3  DOA Other: 4 Nursing Hol	ne 5 🔀 Residence 6 🗌 Other (Specify)								
27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier 1 XCertifying Ph	ysician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the cause(s) and manner as stated.								

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0024687

Oxon Hill, Maryland

29d. Date signed (Month, Day, Year

20745

July 13, 2012

Registrar

State

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ralph Joseph Hindle 30 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death La If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** 6. Sex last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Year) Country) **Director** 217-28-2004 1 🗶 M 2 🗆 F Yrs. 83 Usual Residence of Decedent 04-05-1929 Maryland or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 'natural", or items 23a 10833 Charles Street 20646 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 8 Wood Worker Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Arthur Hindle Lillie Mae Wedding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Brenda Spooner/Daughter 10811 Charles Street La Plata, Maryland 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) Sacred Heart Cem. 07-20-2012 La Plata, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. M00945 211 St. Mary's Ave. La Plata, Maryland 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burialed by the attending physician detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death. Director: After this certificate has autopsy perform 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No filled in by the funeral director, Be 26. Place of Death (Check only one) ၉ Other: npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or meetigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 7 only one occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State

ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State' Registrar 24315 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Α. Herbert 14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Civista Medical Center Charles LaPlata Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs. ocial Security Numbe 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 580-07-3565 1 X M 2 □ F **Director** 91 July 22, 1920 Yrs Nevis, WI 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified VI Frederiksted 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? 23a 108 B Whim 00840 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Examiner Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. ö þ 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 📉 No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Machine Operator 011 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Daniel Herbert Marim Jarvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1321 Frederiksted St. Croix, VI 00840 Christina Herbert/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederiksted Cem. UNK Frederiksted, VI 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Arehart-Echols Funeral Home, PA eri MO0945 P.O. Box 567 LaPlata, Md. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on ,, ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nuknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has k autopsy performed Yes 2 1 Yes 2 No certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 No 1 N Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

24 hours after death. Funeral Director: A: within 2 To the I

completely State Registrar

nly or

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for typing Myrse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Date signed (Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	for State of Maryla State Registrar		tificate of Dea			g. No. 2012	24316	
	Physicia	n/	Decedent's Name (First, Middle, Last)				2. Date of Death  Month  July		3. Time of Death	
	Medic Examin	al	Marian Schumm Hamby  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc		July	10 2012 4c. County of Death	8:55 A M	
	Examin		25715 Chaptico Hill Lane		Chapt			St. Mary	s	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign	
127	Director		577-20-7862 1 🗆 M 2 🛣 F 89  Usual Residence of Decedent	Yrs.			March 23	, 1923 Wash	nington, D.C	
	/land f shov ed at	tor	10a. State 10b. County 10c. C	City, Town or Loc	cation				10d. Inside City Limits	
	e Man r 28a- notifie	Direc	Maryland St. Mary's Cha	ptico	10f. Zip Code		1.0	g. Citizen of What Cou	1  Yes 2 No	
	with th	Funeral Director	25715 Chaptico Hill Lane		20621		10	USA	пиуг	
	items		11. Marital Status  12. Was Decedent Ever in Under Forces?	J.S. 13. V	Was Decedent of Hispar f Yes, specify Cuban, M	nic Origin? (Spec Nexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X ☐ No If Yes, Give Year or Dates.	1	☐ Yes 2X No S			Specify: Whi		
15-(	72 hou n "nat fedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupation kind of work done durin O NOT use retired)	n ng most of workir	10	6b. Kind of Business/In ederal	dustry	
212	within giene. er than		Elementary/Secondary (0-12) College (1-4 or 5+)		al Carrier			overnment		
	filed tal Hyg	To Be	17. Father's Name (First, Middle, Last)				(First, Middle, Ma	· · · · · · · · · · · · · · · · · · ·		
Z	d Men marke matic		Franz Xavier Schumm  19a. Informant's Name/Relationship (Type, Print)					chneider :	0-4-1	
Baltimore, Maryland	12 shoalth an 27 is 27 is ir trau		Elizabeth Ousley/ Daughter	111	-			ity or Town, State, Zip yland 2177		
ore,	of Hez of Hez if item		20a. Method of Disposition  1	Place of Dispo				Oc. Location - City or To		
ţ	t. Page tment tant: I jury o		4 ☐ Donation 5 ☐ Other (Specify) Mar	yland \	/et's Cem			Cheltenha	m, MD.	
Bal	permir Depar Impor any in		21. Signature of Funeral Service Licensee  Brune		Name and Address of 035 01d Was			ral Home dorf, MD.	20601	
	Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the deschock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  St. punting list conditions if any, leading to immediate cause. Enter Underlying	n) () quence of):	none ?				Approximate Interval Between nset and Death	
	icate be executed physician and is the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consecutive consecution)	quence of):						
1760	icate by physical phy	<b>ledical</b>	d							
Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregrate 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year		
s, P.O.	requires that the des been signed by the s should be detached	d by Pr	Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause given i	in Part I.		cco use contribute to t		
Records,	The law requate has bee page 2 shou	Complete	of ling linear	1-20.	section		24a. Was an autopsy performe	prior to co death?	psy findings available impletion of cause of 2 av No	
ta	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:		26. Place	of Death (Check	only one)	•		
of V	y Phys er this eral di	e: To	1 Ves 2 No 1 Inpatient 2 27. Manner Death 28a. Date of injury	28b. Time of	1t 3 □ DOA 4		me 5 Resident 28d. Describe how	ce 6 Other (Specify injury occurred	()	
on (	ending eath. or: Afte he fun	ficat	1 atural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	M work?  I □ Yes	2 🗆 No				
Division of Vital	al or Attending Ph s after death. Il Director: After th ed in by the funeral	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At I building, etc. (Special Could not be determined building).	nome, farm, stre	eet, factory, office		8f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director, After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examinationly one) 3 Certifying Nurse Practitioner: To the best of	ion and/or invest	tigation, in my opinion, d	leath occurred at	the time, date and	place, and due to the ca	use(s) and manner stated.	
	Toth withi		29b. Signature and title of certifier	_	20a Liganga pur			d. Date signed (Month,		
	00.33		30. Name and address of person who completed cause of death (Ite	em 23a) (Type, P		m. /	XD X	LE M.1)		
	Stat Registra		31. Date filed (Month, Pay, Year) 7 2012 32. Pégistrar's Sign	nature	aks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 8/9/12 #21 per FH G930 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JuM9th 14 2012 2137 Рм Janice Cullember Hall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 13 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 ⋤ F 71 Yrs. Director 1941 Maryland 215-38-7265 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, he Medical Evancial in ust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Calvert Prince Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20678 1555 Mallard Point Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ∐Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž☐ No Specify. Completed by Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Mutual Fire Ins. secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Irene Walton James William Cullember 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1555 Mallard Point Rd. Prince Frederick MD 20678 Robert D. Hall, Sr. - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Asbury Cemetery July 18 2012 Barstow Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home 20676 Barbara Rausch per DVR 4405 Broomes Island Rd. Port Republic Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Acuto /Medical Due to (or as a consequence of): Examiner ONLONGE Sequentially list conditions. se Jentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of) attending physician for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Lectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) the should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 X Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe (es this certificate 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only onle) 1☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 0027189 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1289 WALDORF, drw MO 31. Date filed (Month, Day, 32. Registra s Signature State JUL 16 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Jack W. Hunter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western Maryland Regional Medical Ctr Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 212-38-5437 1**X** M 2 □ F April 23,1940 Maryland Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits at Director Examiner must be notified LaVale MD Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 U.S.A. Funeral 21502 or items 23a 12401 Butler Dr. NW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1958 à 1 Never Married 2 Married within 72 hours after Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced White Completed 1962 Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Law Enforcement Dispatcher - Allegany Co Sher 12 event, t Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is meany injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Geneva (Filer) Hunter Charles W. Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy G. Hunter 12401 Butler Dr. NW, LaVale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Frostburg Memorial Pk July 25,2012 Frostburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, P.A. Signature of Funeral Service Licenses tohn 1302 National Hwy., LaVale, MD 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Adenocaremona disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and I for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year Pregnant at time of death signed by the at I be detached fo 1 Yes 2 L 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 N within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 🕱 No 1 Nonpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniun 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ortifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 07-23-2012 000 2337 E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12502 Willowbrook Rd. Ste: 440 Cumberland, MD, 21502 Qamar Zaman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July Chu Thanh Hoa 2012 6:10 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 220-33-6782 Director 1**X** M 2 □ F 55 Oct. 11, 1956 Vietnam 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 11<u>000 Inwood Avenue</u> 20902 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black White, etc. à 1 Never Married 2 Married ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 A No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Shipping Clerk Pittcon Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be file of Mental marked o ٥ Uyen Thuc Chu Luan Thi Phan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 Kimphuong Nguyen/Wife 11000 Inwood Avenue, Silver Spring, MD 20902 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: if its eny injury or ot 1 😡 Burial 2 🗆 Cremation 3 🗀 Removal from State July 16, Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ a.Stomach Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) e attending physician and ed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown this certificate has been signed by the a ral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospice 6 Other (Specify) 1 Yes 2 XNo Other: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral din 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D37142 July 11,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive, Rockville, MD 20850 G. Coleman, MD 31. Date filed (Month, Day, Year) State 13 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene FoAMEND#12 per FH State 7/10/12 AACO HEALIH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:10 A.M, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death MANDRIN CHESAPEAKE HOSPICE HOUSE HARWOOD ANNE ARUNDEL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Hours Country) Director 1 □ M 2 □XF 301-14-3192 88 6/16/1924 DELTA OHIO Usual Residence of Dece and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 20904 12601 GALWAY DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Year or Dates. 1944 Specify: WHITE 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CASHIER FOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ě OLIVER WILEY OLA SMALLMAN Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 308 GREENRIDGE DRIVE, DUNKIRK, MD 20754 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t PATRICIA STARR/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 7/10/2012 4 Donation 5 Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee The and Address of Facility LAS $ENBEIN \& NEWNAM \\ BESTGATE ROAD,$ 21401 ANNAPOLIS MDPage . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Approximate Interval Betw Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons quence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to jui as a suffisequence of sician and burial-transit Exam or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an performe To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? יין אַעעויי*יו*וע Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner To the best of my knowledge, death of at the time, data and place, and due to the cause(s) and menner as stated 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year)

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of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24321 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 12:02 Harvey LaFarn Dorothy Tulv 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles White Plains 4029 Baron Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Min 1 M 2 XF 78 229-38-6999 Yrs Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County **Funeral Director** 1X Yes 2 ☐ No Prince George's Ft. Washington MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 20744 7605 Blanford Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. SpecifyBlack 3 ▼Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 + Elementary/Seconday (0-12) U.S. Government Management Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edmonia Gray Thomas Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7605 Blandford Dr. Ft. Washington, MD. 20744 Harvey/Son Marquis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/15/2012 Goochland, VA Chief Cornerstone 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe Tonic Funeral Home Old Washington Rd. Waldrof, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and as the burial-trar Due to (or as a consequence of) attending physiciar Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Daughter's Residence Hospital Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Dath 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pendina Matural s after death. 2 🗆 No 2 Accident 1 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month

Davis

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Donald Wade Hamilton July 2012 ear 9, 9:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Northampton Manor Nursing Center Frederick 5. Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Hours (Month, Day, Year, Country)
Maryland **Director** 212-68-9508 1 🛛 M 2 🗆 F 54 Nov. 15, 1957 Usual Residence of Deced 23a or 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-fs' event, the Medical Examiner must be notified Maryland Frederick Union Bridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9097 Holly Court United States 21791 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🗷 No Specify Specify:White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Plumber Plumbing & Heating and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Hamilton Joyce Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $9097\ \ Holly\ Ct.,\ Union\ Bridge,\ MD\ 21791$ Department of Health ar Important: If item 27 is any injury or other trauonce. Linda Hamilton / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven Crematory 20c. Location - City or Town, State July ll, 1 🗋 Burial 2 🗵 Cremation 3 🗌 Removal from State Frederick, Maryland 4 Donation 5 ther (Specify) 2012 21. Signature of Funeral Service Licensee Resthaven Fufferal Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Envir the due se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart fribre. List only one cause on each line. nset and Death COLON ( KM CEL Physician/ ETASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 🗆 No Yes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29c. License number 0006 LLL3 July 11, 2012

Registrar DHMH 17 Rev 06-2011

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196 TJONEVE, PREDENCE, 17 921702.

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

H BOLANUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24323 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Edith Helene Hull 2012 0403 Medical 07 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HICAMICO REGIONAL Center TENINSULA Medical SALISBULY Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) (Month, Day, Year) Director 1 □ M 2 🔯 F 452-35-3392 53 07/22/1958 Maryland or than "natural", or items 23a or 28a-f show 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico 1 Yes 2X No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1221 Flamingo Drive 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes Give 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Hovorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed - Attorney permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Importent: If item 27 is marked othe any injury or other traumatic event, Be Purner's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Sidney Hull Agnes Purnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 Flamingo Drive - Salisbury, MD 21801 Agnes P. Hull/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 07/11/2012 4 Denation 5 Other (Specify) Salisbury Crematory Salisbury, MD Signature of Funeral Octvice Licenses 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that raused the shock, or heart failure. List only one cause on each line. p not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequ attending physicien and I for use as the burial-translt that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate To the Hospitel or Attending Physicien: I within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work: 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 ☐ Medical Examine 3 ☐ Certifying Nurse Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sian D0052198 pleted cause of death (Item 23a) (Type, Print) MICHAEL SOFRONSKI 100 EAST CARROW STREET, SALISBURY, State

DHMH 17 Rev 06-2011

Registrar

			Pleas	e Type or Prii					_		_	•
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			Registrar			C	Certificate of L	Death		Reg. N	0. /	2 24321
	Physicia Medic		Decedent's Name (First, Middle, L     Claudia Ann Inga	agliato					2. Date of Dea	ath	y 20 TS	3. Time of Death 9:46 P. M.
	Examin	er	4a Facility Name (if not institution, g	ive street and number)	Cer	Ter	4b. Gity, Town, or	PLATA	/	4	c. County of Dea	165
	Funeral Director			Sex 7. Age	e (In yrs. las 76	st birthda Yrs	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da )ct. 17	h y, Year)	g. Bir Cco	thplace (State or Foreign untry)
59	Mo		Usual Residence of Decedent  10a. State 10b. County						700. 17		700 710011	
3/5	Aarylan 8a-f sh tified a	Director	Maryland Charles	,		ildor	Location					10d. Inside City Limits 1   Yes 2 □ No
1	ith the h 23a or 2 st be no		10e. Street and Number				10f. Zip Code	11		10g. C	Citizen of What Co	ountry?
Ž	ath w	Funeral	2930 St. Peter's	12. Was Decedent E		. 1	2060 3. Was Decedent of H		cifv Yes or No-		14. Race - Ame	erican Indian
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland benefithent of Health and Mental Hygiene. Inportant if liem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	Armed Forces?			If Yes, specify Cuba 1 ☐ Yes 2 <b>X</b> ☐ No	in, Mexican, Puerto I	Rićan, etc.)		Black, Whit	
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7 5	of Head of Head fitem rothe		20a. Method of Disposition  1 🕅 Burial 2 🗆 Cremation 3	_	20b. Pla	ace of Di	sposition (Name of crematory or other place		Pate		Location - City or	
C/AUC Baltimore	t. Page tment tant: I		4 Donation 5 Other (Spe	ecify)			i Vets' Cen	n. July			Cheltenh	am, MD.
0 2	permir Depar Impoi any ir		21. Signature of Füheral Service Lice	nsee			22. Name and Addres				al Home	20601
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HOX 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 Fetal	death	3	Sy			23d. Date of de Month	livery Day Year
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<u> </u>	in: Th tificat tor, pa	Be C	25. Was case referred to medical				26. Pl	ace of Death (Check	1 PYes	2 LIN	io 1 Ll Yes	s 2 No
Ë	ysicia is cer direct	To B	examiner? 1  Yes 2 No	Hospital:	ent 2 🗆 E	ER/Outpa	atient 3 DOA Othe		-	lence	6 Other (Spec	eify)
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Sion	Attend r death ector: /	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be 28e. Place of Inju	ıry - At hon	ne, farm,	M 1 □ street, factory, office	Yes 2 □ No	28f. Location (S	itreet ar	nd Number or Ru	ral Route Number,
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	he Hos in 24 h he Fun pleted	Medical	(Check 2 Medical Exa		xamination	and/or in	vestigation, in my opinio	on, death occurred at	the time, date a	nd plac	e, and due to the	cause(s) and manner stated.
4	To the with To to com		29b. Signature and title of certifier				29c. License	+ 5 7 3	7	29d. Di	ate signed (Monti	h, Day, Year)
	ma-5		30. Name and address of person wh	o completed cause of de	eath (Item 2	23a) (Typ	e, Print) 3378 (1)	- Lubschi	ritor	Rol	Wald	af MD
l.	Stat Registra		31. Date filed (Month Pay, Year) 8 2	012 3 Registra	ar's Signatu	Je A	backer	7 7001716	7/01	, —		20602

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		State Registrar				Cei	tificate	of E	Death			Reg. N	lo. 2 (	1 2	24325
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Funeral		5. Social Security No. 488–28–76			Age (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth a <i>y, Year)</i>	, ]		nplace (State or Foreign
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nd 2 shoul aalth and I m 27 is m		19a. Informant's Na Nancy Re	burn/Ni	(Type, Print) <b>ece</b>		19b. Mailir 4408	ng Address Broo	(Street a kf <b>i</b> e	and Numbe ld Dr	r or Rura ive,	Route Number	er, City o ngt c	or Town, S	tate, Zip D 20	Code) 1895
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hyglene. Important: If Item 27 is marked other than "naturel", or items 23a or 28a-f sho any injury or other traumatic event, the Madical Exeminer must be notified at once.				Removal from St	ate Ga	Place of Dispo emetery, cren te of Ceme	sition (Nam patory or o Heave tery	ne of ther plac N	e)	July 2	20, 2012	ı		-	Town, State
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		23a. Part 1. Enter to showk or hear	he disease, or controller	omplications in t cau y one cause on each	sed the deatl line.	h. Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
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P Mitt		29b. Signature and to	title of certifier	rus n	np		29c.	License D3	number				ate signed $\mathrm{uly}$ .		
		Warren	Ferris,	o completed cause of MD 330	f death (Item 5 N. I	23a) (Type, F Leisure	rint) Worl	Ld B	lvd.,	Sil	ver Spi	ring	, MD	2090	06
State Registra	~	31. Date filed (Monti	h, Day, Year) L 17 2(	37. Regi	strar's Signat	Jure for	N. J								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jack Carl Jacobsen CCC Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 361-20-9808 **Director** 1 **X** M 2 □ F 84 Jan. 5, 1928 Wisconsin Usual Residence of Dec r 28a-f show notified at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits NJ Morris Montville 1 X Yes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 39 Schneider Lane 07045 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Armed Forces' Black, White, etc. 6 þ 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: White 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Executive Vice President Manufacturing other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o Department of Health and Menta Important: If item 27 is marked any injury or art. မ Karl A. Jacobson Lillian Sorenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane T. DiNardo/Daughter 19335 Ranworth Drive, Germantown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 7/17/2012 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause of hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury Examine executed tran that initiated events resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 t 12 mont 2 No Month Pregnant at time of death Day Year 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 욘 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Mann o Death 28b. Time of Certificate: Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be Accident filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

41

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatui

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gwendolyn Patricia Johnson-Zimmerman  $J_u^{\text{Month}}$ 2012 4:34 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cumberland 220 Somerville Avenue, Apt 506 Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 01/07/1922 Director 291-18-9928 Pennsylvania 1 □ M 2X F 90 Vrs permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marked once. 10b. County 10c. City. Town or Location 10d. Inside City Limits Completed by Funeral Director MD Cumberland Allegany 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 Somerville Avenue, Apt 506 220 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black. White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Clerk Typist Be Mother's Name (First, Middle, Maiden Sumame)
Grace White 17. Father's Name (First, Middle, Last) ည Williams John Helen James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street *and Number or Rural Route Number, City or Town, State, Zio Code)* 13017 Mallard Street, Cumberland, MD 21502 Charles G. Johnson / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Mem. Gardens 07/12/2012 LaVale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Alams Family Funeral Home, F.A. Signature of Funeral Service Libensee 404 Decatur Street, Cumberland, MD Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Metatic Onset and Death Physician/ disease or condition resulting in death) Few monthly Medical Due to (or as a consequence of): Examiner Sequentially list conditions, for your cause. Enter Underlying Cause (Disease or injury Examine Directo (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Other (specify) Month Year 1 Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of eertifier 29c. License number 29d. Date signed (Month, Day, Year) D46346 July 9, 2012

State Registrar 31. Date filed (Month, Day, Jed L 0 9

sarke

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Huma Shakil, M.D., 625 Kent Avenue, Cumberland, Maryland

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Paul William Jones Sr. 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanham Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Hours Min. (Month, Day, Year) 578-48-2012 1 ፟ M 2 □ F Feb. 18, 1937 DC Usual Residence of Decedent 75 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No <u>Maryland</u> Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 United States 6027 Springhill Drive #102 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married African If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Transportation Supervisor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Jones Mabel Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robbin Jones- Wife 6027 Springhill Drive # 102 Greenbelt, Md. 20770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State

 $\bar{2}\bar{0}\dot{1}2$ 

22. Name and Address of Facility Stewart Funeral Home, Inc.

4001 Benning Road NE Washington, DC

Landover, Maryland

29d. Date signed (Month, Day, Year)

Good Luck Rd. Lanham, Md 20706

2012

Department of Health and Mental Hygiene. Important: If items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.

Examine

Be Completed by Physician/Medical

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Medical Certificate:

Physician/ Medical **Examiner** 

Physician/

Medical

Director

Funeral

by

Completed

Be

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4 ☐ Donation 5 ☐ Other (Specify)

Signature of Funeral Service Licensee

tewan

**Examiner** 

**Funeral** 

**Director** 

28a-f show

with the Maryland

Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after

> To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran physician use as t for detached signed by t d be detach page 2 should has certificate director, After this filled in by the funeral within 24 hours after death.
>
> To the Funeral Director: All completely filled in by the fu

Division of Vital Records, P.O. Box 68760

23a. Part 1. Enter the disease, or companies shock, or heart failure. List only o	plications that caused the death. Do not enter the mode of dying, such as cardiac or res ne cause on each line.	piratory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition	Authority Transfer Discour		Onset and Death
resulting in death)	a. Atherosclerotic Heart Disease  Due to (or as a consequence of):		
	Due to (or as a consequence or).		
Sequentially list conditions,	b. ————————————————————————————————————		
if any, leading to immediate	Due to (or as a consequence of):		1
Cause (Disease or injury that initiated events			
resulting in death) Last	Due to (or as a consequence of):		
	d		
IF FEMALE:			
Zob. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of de	elivery
in the past 12 months?	4 Pregnant at time of death 5 Other (specify)	Month	Day Year
9 🗌 Unknown	9 Unknown		
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?
Chronic Kid	lney Disease	1 ☐ Yes 2 ☐ No 3 ☐ F	
		ILIYes ZLINO 3LI	Probably 4 Latunknown
			utopsy findings available
		performed? death?	
		1 ☐ Yes 2 🔀 No 1 ☐ Ye	s 2 No
25. Was case referred to medical examiner?	26. Place of Death (Check only	one)	
1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 Residence 6 Other (Spe	cify)
27. Manner of Death	28a. Date of injury 28b. Time of 28c. Injury at 28d.	Describe how injury occurred	
1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) injury work?  M 1 Yes 2 No		
3 Suicide 6 Could not b	e		
4 Homicide determined		Location (Street and Number or Ru City or Town, State)	ural Route Number,
29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, death occurred at the time, date and place, and du	ue to the cause(s) and manner as s	tated.
(Check 2 Medical Exami only one) 3 Certifying Nurs	iner: On the basis of examination and/or investigation, in my opinion, death occurred at the t se Practitioner: To the best of my knowledge, death occurred at the time, date and place, a	ime, date and place, and due to the	cause(s) and manner stated
		ind doc to the oddoo(s) and mainer	do otdiod.

Harmony Cemetery

00560

DHMH 17 Rev 06-2011

State Registrar

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 3, **2**012 2255 Sandra M. Jackson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Hours Director 1 □ M 2 🔀 F 579-66-1642 62 Sept. 8, 1949 Usual Residence of Deced DC or 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director be notified Silver Spring 1 X Yes 2 ☐ No Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a must | 20906 United States 12800 Epping Terrace items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc 5 þ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 er than "natural", c , the Medical Exam Black If Yes, Give 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Je filed wn...
\*al Hygiene.
\*ar than "r (Specify only highest grade completed) Elementary/Secondary (0-12) 7 th College (1-4 or 5+) Disabled Private other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ည James Diggs Margaret Davis 19a. Informant's Name/Relationship (Type, PrinDaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Tinika Jackson Mattocks -20232 Grazing Way Montgomery Village, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Tate 6. Department of Important; If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Landover, Maryland Harmony Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. tions of T M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MYELOID REFRACTORY ACUTE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death Year the 9 🗌 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director: After this certification prompletely filled in by the funeral director, and the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 074354 7/10 COPRIVALKAR

Registrar
DHMH 17 Rev 06-2011

Washington, DC

3800 Reservoir Road NW

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kopriwnika

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>D</sup>2012 Physician/ Laura Anderson Hopkins  $J_{u}^{\text{Month}}$  14, 14:35 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Berlin Worchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Davs Hours Min 1 🗆 M 2 😾 F **Director** 578-18-8044 90 Feb. 23,1922 Washington DC Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 Yes 2 No Prince George's Maryland Upper Marlboro 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? Funeral 20772 4501 Wyvill Road USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XXNo the Medical Examiner Black, White, etc. ö 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: White "natural", Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Legal 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental ! ည Philip Bruce Anderson Κ. Hoffman Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 9000 Bay Ave, Unit 210, North Beach, MD 20714 Philip Carl Hopkins - Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of July 19 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Upper Marlboro, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sevice Licensee

Amanda M. Reg Le Epis. Ch. Cemetery 2012 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Artery Due to (or as a con a quence of) disease or condition Medical resulting in death) Examiner Hyperlipidemia Sequentially list conditions, Examine cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Physician/Medical use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Pregnant at time of death signed by the at detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 Z No 1 Inpatient 2 I ER/Outpatient 3 100A 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 1 A Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) H006646Z 30. Name apeladdress of person who completed cause of death (Item 23a) (Type, Print)

Je Freq K. Schei Rer , 85/3 track Rd. Berlin, MD 21811 drw 32. Registra s Signature State Registrar

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Laura

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		1 - State of M Registrar	laryland / De <i>C</i>	partment of I <i>ertificate of</i>			ene g. No. 2012	24331
Physic /Med			Ketner			2. Date of Death Month July 15,	Day Year	3. Time of Death 9:40 PM
Exam Funera Directo	1	4a. Facility Name (If not institution, give street and number  Burnett Hospice House  5. Social Security Number  6. Sex  1 M 2 XX  Usual Residence of Decedent	ge (In yrs. last birthda 98 Yrs	Prince  If Under 1 Year  Months Days	Hours Min.	8. Date of Birth (Month, Day, March 26	4c. County of Death  Calvert  Year)  9. Birth  Cou  0,1914  Wa	place (State or Foreign ntry) shington DC
Maryland I-f show	tor	10a. State 10b. County Maryland Calvert	10c. City, Town or	Location Leonard				10d. Inside City Limits 1 □Yes 2XXNo
th with the 23a or 28a	al Director	10e. Street and Number 310 Madeline Drive		10f. Zip Code 2068.	5	10	g. Citizen of What Cou	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ing Madical Examinar must be retilled at any one.	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Nidowed 4 Divorced  1 Yes, Give 4 Year or Dates:	X <sup>No</sup>	3. Was Decedent of I If Yes, specify Cub 1 □Yes 2 ▼No	Hispanic Origin? (Spe an, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W	
within 72 ho ene. than "natur	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	5+) (G	ecedent's Usual Occupive kind of work done e. DO NOT use retire	during most of working		6b. Kind of Business/Ir  Own Home	dustry
uld be filed v Aental Hygid rked other tic event, tr	To Be Co	11 17. Father's Name (First, Middle, Last) Francis Bernard Carro		memaker	18. Mother's Name	(First, Middle, M	laiden Surname)	
and 2 shortealth and 1 to 27 is mather trauma		19a. Informant's Name/Relationship (Type. Print)  Lynne A. Nutter - Daughte	er 310	Madeline	Drive, St	. Leonar		85
nit. Pages 1 artment of H ortant: If ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	;	sposition (Name of rematory or other pla	ery 20	20 <b>,</b>	Washington	DC
perm Depa Impo		21. Signature of Fundral Service Licensee  That are the disease, or complications that cause		8200 Jenn	ifer Lane,	Owings,		
Physician		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	sa consequence of):	recest C	CLMCON.	теврпаюту атте	si,	Approximate Interval Between Onset and Death
Examine		Seguentially list conditions.	s a consequence of):					
asth certificate be executed attending physician and for use as the burial-transit		trial initiated events C.	s a consequence of):					
The law requires that the death certificate be also been signed by the attending physicia bage 2 should be detached for use as the buri	ysician/Medical		2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	гу		23d. Date of deliv	very Day Year
w requires that the de s been signed by the a	ed by Phys	Part II. Other significant conditions contributing to death  Technology  Techn	but not resulting in the	e underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to s	the cause of death?
: The law ricate has be page 2 she	Completed					24a. Was an autopsy perform 1 □ Yes 2	/ prior to co	opsy findings available ompletion of cause of 2 □No
ding Physician: The Ih. After this certificate he functal director, page	: To Be		ient 2 ER/Outpa	tient 3 DOA		ne 5 ☐ Resider	nce 6 Other (Spec	Hospice
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	ertification:	1 Natural 5 Pending (Month, D) 2 Accident investigation 3 Suicide 6 Could not be	jury 28b. Time Injury - At home, farm, tc. (Specify)	y Wor M 1 □	]Yes 2□No		w injury occurred reet and Number or Run State)	al Route Number,
e Hospital 24 hours e Funeral	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the besis and manner sand mann	of examination and/o	eath occurred at the t r investigation, in my	ime, date and place, a opinion, death occurre	and due to the ca	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. Licens	se number		7-16-12	Day, Year)
daw 5	4	30. Name and address of person who completed cause of Raymon A 18 Se W	death (Item 23a) (Typ	Me (i)	mac C	J. Pr	ince Fue	J.M.D
Regis	_	31. Date fled (Month, Day, Year) 32. Regis JUL 17 2012	Pereur A	1. park	•	/		ノ <u>*</u>
HMH 17 Rev 1	/2()01							

AMEND #3 PER MD G929 7/31/12 TRI Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** atharine Elizabe 2:55 P Kouvavas 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner uture Care Chesapeake Arnold, Anne Arunde Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2**X**F Months Days Hours Min. 178-16-6307 Director 0/30/1920 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Anne Arunde Arnola mp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 College Parkway 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify à 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbur Dietz, Sr may 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, MD 211
Date 20c. Location - City or Town, State Joanna Ostrowski 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/2012 Mechanicsburg, PA Chestnut Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 37 E. Main St., Mechanicsburg, PA 21. Signature of Fundal Service Live 22. Name and Address of Ficility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spread to the disease of the Approximate Interval Between Onset and Death Immediate Cause (Final Physician 0 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to hitmodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (unas a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has I funeral director, page 2 s autopsy 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 4 hours after death uneral Director: / 2 Accident the 1 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00073574 completed cause of death (Item 23a) (Type, Print) referant May, Suite 204 Natavank 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are begible.

State of Maryland / Department of Health and Mental Hygiene

			State Registrar				Ce	rtificate of	Death	h		Reg. N	lo.			
	Physicia	an/	1. Decedent's Name		,						2. Date of D				3. Time of	
	Medi	cal	Kathryn								07	0	ay	Year	62	3 pm
	Exami	ner	/	. 1	give street and number)	1	/_	4b. City, Town,	or Locatio	on of Death	1	4	c. County	of Death	. 0	
-	Funeval		5. Social Security No	HOSDice		aK	est birthday)	If Under 1 Year	isc	ur	<u> </u>		Wi	con	uco	_
	Funeral Director		214-10-7			ge (in yrs. ia 92	,,	Months Days		der 24 Hrs. Min.	8. Date of B			<ol><li>Birthpl</li><li>Counti</li></ol>	ace (State or y)	Foreign
			Usual Residence of		T I W Z Z T	-	Yrs.				07-28	3-191	19	VA		
	land sho	후	10a. State	10b. County		10c. Cit	y, Town or Lo	ocation						10	d. Inside Cit	y Limits
	Mary 28e-f	Director	MD	Wicomi	.CO	Sali	isbury								1 🗆 Yes	2 🗌 No
	e or		10e. Street and Nun	nber				10f. Zip Code				10g. C	itizen of W	hat Count	ry?	
	h with	Funeral	1110 Hea	lthway	Dr.			21804				US	A			
	deat item		11. Marital Status		12. Was Decedent Armed Forces?			Was Decedent of I	Hispanic (	Origin? (Spe	cify Yes or No	)-	14. Race			
36	efter	d b	1 Never Marri 3 X Widowed		ed 1 ☐ Yes 2 🔀		1	1 ☐ Yes 2 🔯 N			modif, ctc.,		Black Specify:	White, et		
ا 215-0036	atura col E	Completed	3 tas vvidowed 2	15. Decedent	Year or Dates.								Specify:			
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Xoland 21	filed foth vent	Be	17. Father's Name (F	,	st)		OWITE		18. Mo	ther's Name	(First, Middle			CC		
Aan X	d be Menta	2	Edwin F.	East					B€	eatric	e Mae	Tayl	or			
Mary	shour and is m		19a. Informant's Na	me/Relationship	p (Type, Print)		19b. Maili	ng Address (Street	and Num	ber or Rural	Route Numb	er, City o	r Town, Sta	te, Zip Co	ode)	
2≥	nd 2 leaith m 27		John B.		IV		5	East Mai								
\$ 8	tof H if ite or oth		20a. Method of Disp		B ☐ Removal from State	20b. P	lace of Dispo	osition (Name of matory or other pla	ice)	D	ate	20c. L	ocation - C	ity or Tow	n, State	
Kath altimore,	permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23e or 28e-f show eny injury or other treumatic event, the Medical Evaruiner must be notified at once.		4 Donation	5 Other (Sp	ecify)	Par		Cemetery		8-3-2	012	Sal	isbur	y, M	D	
Bai	bepar mpor my in		21. Signature of Fun	eral Service Lic	ensee	_		2. Name and Addre								
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	ted ansit	Examiner	cause. Enter Underl	ying S	040 10 (01 40	a consequ	crice oi).									
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isi	Atter	<b>Ę</b>	3 Suicide	6 Could no determine	t be 28e. Place of Inju	ry - At hon	ne, farm, stre		les ZL		Bf. Location (S	Stroot on	d Number	e Duent De	nuto Alum tum	
Division of Vital Records, P.O	s after			- determine	building, etc	. (Specify)		, , , , , , , , , , , , , , , , , , , ,		-	City or Tow	vn, State)	)	i nurai no	oute Number,	
	dospit 4 hou uner uner eiy fiii	Medical	29a. Certifier 4-E	Certifying Pl	hysician: To the best of expiner: On the basis of ex	ny knowle	dge, death o	occurred at the time	e, date an	d place, and	due to the ca	ause(s) ar	nd manner	as stated.		
	To the Hospital or Attending Physicien: The law requires thet the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	— F	only one) 3	Certifying N	miner: On the basis of exurse Practitioner: To the											er stated.
	<b>८</b> ₹ <b>८</b> छ		29b. Signature and tit	fe of certifier				29c. License		110			e signed (/\)			
	-0							DEC	7 84			0	7/0-	2/12		
	170		30. Name and addres	s of person who	o completed cause of de	ath (Item 2	23a) (Type, P	rint) 177	3	Chi.	0,0	/	/	7	(Y	
	Stat	ρ_	31. Date filed (Month,	Day, Year)	32. eqistra	r's Signatu	1906	1/3	_	of 3	12 Mel		w	( )	000	
	Registra	_			2012 Dem	U K	1. 100	are			/					
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KONNER MALINDA

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		For State of N	Maryland / Dep			Mental Hy	giene 2	012 24331	(American
	_	Registrar  1. Decedent's Name (First, Middle, Last)	Cei	rtificate of De	eatn	2. Date of Dea	Reg. No.		_
Physicia Medi		Malinda Grace Collins Ker				July July	Day	Year 9:134 M	_
Exami	ner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L			4c. County		
Funeral		Doctors Community Hospita  5. Social Security Number 6. Sex 7. A	3 ⊥ ge (In yrs. last birthday)	If Under 1 Year	anham If Under 24 Hrs.	8. Date of Birt	h	ce George's  9. Birthplace (State or Foreign	-
Director		578-24-8745 1□M2⊠F	Yrs.	Months Days	Hours Min.	(Month, Da		Country)	
d	_	Usual Residence of Decedent  10a. State 10b. County	95 10c. City, Town or Lo	)		Dec. 24	, 1916	Virginia 10d. Inside City Limits	-
arylan a-f sh fied a	Sch		Toc. Oity, Town or Ed	Jeation	Mitchel	1		1 😾 Yes 2 🗆 No	
he Mis or 28	Ö	Maryland Prince George's  10e. Street and Number		10f. Zip Code	MILCHEI	TVIITE	10g. Citizen of		-
with t s 23a ust b	Funeral Director	11502 Chantilly Lane		20721	l		United	d States	
death item:		11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc.	
laryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ted by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	XI No	1 Yes 2 🔀 No			Specify	R1 a als	
72 hou	plet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupati kind of work done dur	ion ring most of work	king	16b. Kind of B	usiness/Industry	
ithin 7	Completed	Elementary/Secondary (0-12) College (1-4 or 12 th	(5+) // // // // // // // // // // // // //	Nurse Nurse			Sel	f-Employed	
iled w other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle,	Maiden Surname	e)	-
ylar d be f Wenta arked artic ev	은	Lindsey Collins				Sallie		unk.	
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", on any injury or other traumatic event, the Medical Exam proces.	1	19a. Informant's Name/Relationship (Type, Print)  Sharon Kelsey - Daughter	19b. Maili 1311	ing Address (Street and 0 Kevertor	d Number or Rur n <b>Drive</b>	al Route Numbe Upper 1	r, City or Town, S Marlbord	State, Zip Code) O, Maryland	
imore, Page 1 and ment of Heg ant: If item ury or othe		20a. Method of Disposition 1 ☐ ★Burial 2 ☐ Cremation 3 ☐ Removal from State	LG .	matory or other place)	: -			- City or Town, State	
Baltimor permit. Page 1 Department of Important: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		oln Cemete 2. Name and Address	- /	2012		ood, Maryland	-
may and	10.0	John T. Stewar	M00560 4	001 Bennin	ng Road	NE Wasl	nington,		_
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Box 68760 death certificate be attending physicate for use as the l	m/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom	ne of pregnancy	Estania prognancy			23d. Da	te of delivery	
Box	by Physician/Medica		at time of death 5	Other (specify)			Mo	onth Day Year	
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require peen shoulk	lete					24a. Was	an 24b.	Were autopsy findings available	_
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of Vital Jing Physician: After this certific funeral director,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		Lou	e of Death (Chec				_
Phys rthis	은	27. Manner of Death 28a. Date of in	atient 2 ER/Outpatie	ent 3 🗆 DOA	4 ☐ Nursing H		dence 6 - Other		-
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Division of pital or Attending Phous after death. eral Director: After the filled in by the funeral	Certificate:		njury - At home, farm, str etc. (Specify)	reet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,	
语 回 第 篇	Medical	29a. Certifier (Check conly one)  1	examination and/or inves	stigation, in my opinion,	, death occurred a	at the time, date a	ind place, and du	e to the cause(s) and manner stated	d.
To the Hosp within 24 ho To the Fune	2	29b. Signature and title of certifier.	0.6-	29c. License n	number			d (Month, Day, Year)	
Fa		30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	2500	, , ,	TIL	V11 L	-
		Fozia Abdul wahabe,	MD. 8118	8 Good h	wikh	dy Lo	enham	MD. 20706	_
Sta Regist		32. Reofs	trar's Signature						
DHMH 17 Rev 06			-/	-		··			-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 17,2012 Harvey Jean Lemarie' 7:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Homewood Retirement Center Washington Williamsport 9. Birthplace (State or Foreign County) New Jersey If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In vrs. last birthday **Funeral X**X M 2 □ F 067-07-5158 96 August 17,1915 Director Usual Residence of Decedent or 28a-f show 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes XX No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1623 Langley Drive 21740 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 2 □ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 'natural", 3 Divorced Year or Dates. WWII Completed traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Flementary/Seconday (0-12) College (1-4 or 5+) Display Man Retail Dept. Store 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucien Emile Lemarie Ella M. Fitzpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Emily T. Lemarie' - Wife 1623 Langley Drive Hagerstown, MD 21740 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Hagerstown Crematory 07-19-2012 Hagerstown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Juneral Se any 425 S.Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or healt failure. List only one cause on each line. Immediate Cause (Final Providiga. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last andtran Due to (or as a consequence of) -purialattending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year signed by the a 9 Unknown Other significant conditions contributing to death but not resulting i 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔭 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No within 24 hours after oeau..

To the Funeral Director, After this certification in the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **X**No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Date signed (Month, Day, Year,

Registrar

STEPHEN

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1059 Sue Lohr Martha Medical 4b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner Medical Kegional Allegani umberlang If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min Director 215-26-9646 1 🗆 M 2 💢 F 12/09/1930 Pennsylvania Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Cumberland MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21502 11801 Bayberry Avenue, within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. White If Yes, Give Specify 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 ral Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o Pirl ပ Lottie Dorsey William Leon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta. 12608 Henry Drive, LaVale, MD 21502 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau Scott W. Lohr / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State Cem @ Rocky Gap 07/09/2012 Flintstone, MD MD Vet 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, Signature of Funeral Service 404 Decatur Street, Cumberland, MD 21502 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ DISEASE ARRHYTHIMIA disease or condition resulting in death) HEART Medical Due to (or as a consequence of) Examiner HYPORALEMIA Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that the death certificate be executed nding physician and use as the burial-transit CANCEX COLON that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown jo in the past 12 months?
1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No has e 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HMOORE, MD D72287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Moore, M.D., 12500 Willowbrook Road, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ante Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monti Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat **Examiner** 4c. County of Death If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 277-89-7264 1 XM 2 - F Yrs 12/08/10 Maryland 28a-f show 10b. County 10a, State 10c. City, Town or Location notified at 10d. Inside City Limits Director Frederick Frederick 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 27702 ō 10g. Citizen of What Country? ms 23a or must be n Funeral 160 Willowdale Drive Apt E203 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 🔀 Yes 2 🗆 No Specify: Salvadoran Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ျ Martha Lopez Romero Marcelo Lopez Romero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,27702$ Health a Martha Lopez-mother 160 Willowdale Dr. Apt E203 Frederick, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1; t of ! 1 X Burial 2 Cremation 3 Removal from State Department Important: If any injury or Family Cemetery El Salvador 4 Donation 5 Other (Specify) 7/25/12 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Wanda C. Bacon cc0361 20010 3447 14th St., NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of leach line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner quantizibi list conditi as Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last attending physician Physician/Medical P.O. Box 68760 as the k IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Dav Year 1 Yes 2 9 Unknown be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes 2 C 1 Tes Be ( 25. Was case referred to medical examiner?
1 1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Hospital ၉ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director: After Natural 5 Pending Accident Investigation 1 Tes 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse-Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year, State 16

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2012 Month Physician/ LAMOTHE July LAURA ANN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 405-19-4162 Usual Residence of Decedent Director 1 □ M 2 🏋F 40 West Virginia 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 1 Yes 2 X No Forest Hill MD. Harford 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a21050 United States 1818 Cosner Road or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry المالية ورام filed with. خوا Hygiene. خو**r than "r**" (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Murse's Aid Home Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F 7 is marked o ၉ Charles Edward Croft Beverly Ann Bishop 19a. Informant's Name/Relationship (Type, Prin (Husband)). 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other traunonce. Forest Hill, MD. 21050 Christopher E. Lamothe 1818 Cosner Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Carrol 4 ☐ Donation 5 ☐ Other (Specify) Cremation 2012 Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
g Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) been signed by the atter should be detached for I in the past 12 months?
1 Yes 2 No Day Year Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed eral Director: After this certificate has filled in by the funeral director, page 2 1 Yes 2 No Yes 2 No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Medical Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aff To the Funeral Dii 29a. Certifier 🕑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier h.D. Name and address of person who completed cause of death (Item 23a) (Type, Print)

No Min (M. D.) 510 upper Chusa deake Drive # 409, Bei Air, MD 21014

Date filed (Month, Day, Year)

32. Registral's Sonature

State Registrar Date filed (Month, Day, Year)

amothe

M300605801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month .06A 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7\_Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Months Hours 578-62-1994 94 Director 1 M 2 D 4/2/1918 MDUsual Residence of Deced 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** MD Anne Arundel Annapolis 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4000 River Crescent DR. 21401 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 0. Yes 2XXNo Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes XX No Specify. "natural", 3 ₩Widowed 4 Divorced Specify Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me. Once. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ira M. Staley Myrtle Ruch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 855 Cottage Run Davidsonville, MD 21035 Rusty Lamar 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial Paral Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 7/10/2012 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of the control of t Approximate Immediate Cause (Final Physicsian. disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death g Unknown q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform after death.

Director: After this certificate! 1 Yes 2 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🖊 Inpatient 2 🗌 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 No Investigation Could not be Accident filled in by the 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

30 Name and address of

1 0 2012

Registrar

DHMH 17 Rev 06-2011

of death (Item 28a) (Type, Print)

08

EFENSE HWY, ANNAPOLIS, M.D 21401

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 9, Mary Carroll Lee 12:10A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 220-16-4857 Director 1 □ M 2 🗓 F 7/20/1924 Maryland 87 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at with the Maryland Director 28a-f 1 Yes 2 X No Marvland Anne Arundel Edgewater 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21037 141 Marvland Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) "natural", or item edical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 M Married Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker/Mother Own Home event, Be 17, Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname, and Mental F Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce. ဂ္ဂ Charles Carroll Lee Mary Elizabeth VanSant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 141 Maryland Ave., Edgewater, MD 21037 Harvey Wendell Lee/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Cedar Bluff Cemetery 1 🛴 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/13/2012 Annapolis, MD 4 Domation 5 Other (Specify) 21. Signati 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician Obstructu worke Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence on Cause (Disease or injury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of) nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the surrectional property. Division of Vital Records, P.O. Box 68760 for use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failur 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 ☐ Yes 2 🃉 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural
Accident
Suicide iniury 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) LD DOOCK 829

State Registrar

10

gistrar's Signature

exed conte Annapolis MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Physician/ Jean Mandell Litow 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICO TexIN3461 3AL 136411 REGIONAL POINT If Under 1 Year If Under 24 Hrs. ial Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) Director 1 🗌 M 2 🕱 F 191-14-9269 89 Usual Residence of Dece 06/07/1923 Pennsylvania 10b. County 10a. State 10c. City, Town or Location ir then "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director Salisbury 110f. Zip Code 1 X Yes 2 No Maryland 10e. Street and Number Wicomico 10g. Citizen of What Country? Funeral 21801 USA 1012 Evergreen Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: It Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Domestic Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other treumetic event, in once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Goldie Shaffer <u>Abraham J. Mandell</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1243 Destiny Circle, Annapolis, MD 21409 Susan Westenburger/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Easton Cemetery 7/12/2012 Easton, PA 22. Name and Address of Facility
Holloway Funeral Home, Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 al Savios Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bolural Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician and burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and
etely filled in by the funerel director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Day g Unknown 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Naccident 5 Pending 0700 1 ☐ Yes 2 ☑ No tall Investigation 6/29/12 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1012 Evergreen Ave Medical Certifying Physician: To the base Medical Examiner: On the base 29a. Certifier (nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurse Practitio only one) To the within 2 29c. License number 054048 29d. Date signed (Month, Day, Year) 5049 10 OTO dress of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

2012

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>™</sup>Jth 21. 2012 Francis Jr. 1:40PM M James Lee Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 210 Allendale Avenue LaVale Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Sep 24. 1965 216-72-6969 1 🕇 M 2 🗆 F **Director** 46 Usual Residence of Decedent 10a. State notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Cumberland Allegany 28a-f 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 21502 638 Bedford Street USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 □ Yes 2 □ No Specify: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ö þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates ed other than "natural", event, the Medical Exa 3 Widowed 4 Divorced Specify. black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Allegany Co. BOE maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မ JoAnn Paige James Francis Lee, Sr. Informant's Name/Relationship (Type, Print)
Belinda Lee Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 Department of Health ar Important: If item 27 is any injur, or other trau. wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Restlawn Wernorial Gardens 7/25/2012 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name ar Scarpelly Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 James F. Scarpelli, Jr. Per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ON ON THE Medical Due to a s a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician stached for use as the buria Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day signed by the at Id be detached for 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed been Dislipidania 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? No. Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\simeg\) Yes 2 No Hospital (Specify) Specify Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Othe Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After Natural Accident 5 Pending 1 Yes 2 No filled in by the Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Left light of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of certifie 29d. Date signed (Month) Day, Year)

Registrar

(V)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MEMORIA

31. Date filed (Month, Day, Year)

3 0 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Month Day Your	3. Time of Death 1315 hrs
1120114301 11212 11300444	1315 Nrs
Piney Church Road @ Linus Street LaPlata Charles	
Funeral Director 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MW/DD/YYYYY 9. Birthp. Country Number 214-98-8565 1 Mar. 32. Yrs. Months Days Hours Min. July 13, 1980 Mar.	ntry)
214-98-8565   1   M 2   F   32   Yrs.   Sys   Sys   Was   July 13, 1980   Max   Usual Residence of Decedent	ryland
	10d. Inside City Limits 1 Yes 2 X No
Maryland Prince George Oxon Hill  10e. Street and Number 10g. Citizen of What Country	
बु हुन्न   508 Bock Terrace   20745   U.S.A.	
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - America White, etc.	an Indian, Black,
1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify: Specify: Blace	ck
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)	lustry
15. Decedent's Education (Specify only highest grade completed)  16. Rind of Business/Indu  16. Rind of Busines	any
Programme of the state of the s	
Charles Eugene Cooper Stephanie Milstead  7 19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stale, Zij	p Code)
Stephanie Milstead-Adams Mother 6508 Bock Terrace, Oxon Hill, Md. 20745	
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, 1	
20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  wesleyan Memorial Gardens  1 X Burial 2 Cremation 3 Removal from State  Wesleyan Memorial Gardens  1 X Burial 2 Cremation 3 Removal from State  Wesleyan Memorial Gardens  1 X Burial 2 Cremation 3 Removal from State  Wesleyan Memorial Gardens  1 X Burial 2 Cremation 3 Removal from State  Wesleyan Memorial Gardens  1 X Burial 2 Cremation 3 Removal from State  Wesleyan Memorial Gardens  1 X Burial 2 Cremation 3 Removal from State  Wesleyan Memorial Gardens  1 X Burial 2 Cremation 3 Removal from State  Wesleyan Memorial Gardens  1 X Burial 2 Cremation 3 Removal from State  Wesleyan Memorial Gardens  1 X Burial 3 Cremation 3 Removal from State  Wesleyan Memorial Gardens  1 X Burial 3 Cremation 3 Removal from State  1 X Burial 3 Cremation 3 Removal from State  1 X Burial 3 Cremation 5 Other Specify  Wesleyan Memorial Gardens  1 X Burial 3 Cremation 5 Other Specify  2 X Burial 3 Cremation 5 Cremation 6 City of 16 Cremation 9 Cremation	aryland
21. Signature of Funeral Service Modes Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md.	20640
Physician  23a. Part I. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line.	Approximate Interval Between Onset and
Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Due to (or es a consequence of):	Death .
Sequentielly list conditions, but of an an analysis of the sequence of the seq	
cause. Enter Underlying Cause	
events resulting in death) Last Due to (or as a consequence of).	
S Big C UNPENDED C AMENDED	
O 2 to 1 to 2 to 2 to 2 to 2 to 2 to 2 to	y Yeer
23. Was decedent pregnant in the past 12 months?  1	
9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the	cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the 1 Yes 2 X No 3 Probebi	oly 4 Unknown
Spring and the state of the sta	osy findings available inpletion of cause of
Yes 2 No 1 X Yes 2 No 1 X Yes 2 No 1 X Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)	2 No
25. Was case referred to medical examiner? 1 X Yes 2 No	Scene
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
Subject Short    Natural   5   Pending   Investigation   1   1   Yes 2   X   No   Subject Short   Natural   5   Pending   Investigation   1   1   Yes 2   X   No   Subject Short   Natural   5   Pending   Investigation   1   1   Yes 2   X   No   Subject Short   Natural   5   Pending   Investigation   1   1   Yes 2   X   No   Subject Short   Natural   5   Pending   Investigation   1   1   Yes 2   X   No   Subject Short   Natural   5   Pending   Investigation   1   1   Yes 2   X   No   Subject Short   Natural   5   Pending   Investigation   1   1   Yes 2   X   No   Subject Short   Natural   5   Pending   Investigation   1   1   Yes 2   X   No   Subject Short   Natural   5   Pending   Investigation   1   1   Yes 2   X   No   Subject Short   Natural   5   Pending   Investigation   1   Yes 2   X   No   Subject Short   Natural   5   Pending   Investigation   1   Yes 2   X   No   Subject Short   Natural   5   Pending   Investigation   1   Yes 2   X   No   Subject Short   Natural   7   Yes 2   X   No   Subj	Route Number, City
The state of the s	
	se(s)
To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.  To help a figure one of the cause of the	
July 16, 2012	
30 Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State 31 Date filed (Morety Peys 2011) 32 Registrer's Signature	
Registrar  ORIGINAL  ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> July Physician/ Geraldine Conger 11:41 pм Matwey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12711 Feldon Street Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 230-16-1612 Director 1 □ M 2 1 F 91 Oct. 25, 1920 VA show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Silver Spring 1 Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 12711 Feldon Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Administrative Accountant NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nellie Pearle Sauers Gerald Conger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Oakton Road, Gaithersburg, MD 20877 19a. Informant's Name/Relationship (Type, Print) Ronald Gerald Matwey/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cemetery 20a. Method of Disposition Date unk 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Arlington, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. MO 1503 500 University Blvd. W., Silver Spring, 23a. Pat. Inter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): <sup>/</sup>Examiner Coronary Artery Disease Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physiclan: The law requires that the death certificate be executed c. Hypertension that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy After this certificate has been signed by the atter funeral director, page 2 should be detached for i in the past 12 months?
1 ☐ Yes 2 🔣 No Month 5 Other (specify) Pregnant at time of death g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Polymyalgia Rheumatica 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Tyes 2 K No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred 1X Natural 5 Pending n 24 hours after death.

Funeral Director: Af eletely filled in by the fu death. 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours to the Euner completely file 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-201

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State

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31. Date filed (Month, Day, Year)

JUL 17 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francisco A. Matheus, MD 13018 Georgia Avenue, Silver Spring, MD 20906

July 16, 2012

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12-05379 <sub>-</sub> ysander Sam Mo		nee, Jr. 1- For State		<b>pe or Print</b> tate of Mary	land / Dep	oartme	ent of			-	giene		2	The state of the s	2 2 3
Physiciai	_	Registrar  1. Decedent's Nam	ne (First, Midd	lle,Last)		-					2. Date of De	Reg. No eath		3. Time of Death	
Medical Examin				icghee, J	R.						Month Day Year July 17, 2012			r	1915 hrs
	•	4a. Facility Name (	(if not institution				4	b. City, Tow Hyattsvi	n, or Locatio	on of Death	<u>-</u>	4	c. County o		's
Funeral Director		5. Social Security F 216-13-0		6. Sex	7. Age (In yrs	s. last birth	hday) Yrs.	If Under 1 Months		nder 24Hrs. burs Min.	8. Date of B			Foreign	nplace (State or number) NC
nd show any ice.	_	Usual Residence of 10a. State	10b. County	e George'		•	or Locatio				-				10d. Inside City Limits 1 Yes 2 No
sath with the Maryland frems 23a or 28a-f show any ast be notified at once.	Director	10e. Street and Nu		Street				10f. Zip Co				10g. Ci	tizen of Wh	at Coun	try?
p s d	Funeral	11. Marital Status  1 X Never Marri  3 Widowed			ecedent Ever in Forces? 2 X No		If Ye	s, specify C		Origin? (Specan, Puerto R		No-	14. Race White	, etc.	can Indian, Black,
6 n 72 hours aft an "natural"	Completed by		ducation (Spe	or Dates: ecify only highest gr College		- 0	Decedent during mo	s Usual Oc st of workin	cupation (Gi g life. DO N	ve kind of wo		ŀ	Kind of Bus	siness/lr	ndustry
MD 21215-0036 of 2 should be filed within 7 lith and Mental Hygiene. n 27 is marked other than n mun to the filed within 1	Be Comp	17. Father's Name		l yr Last) Chee, Sr		Bag	ggage	Hand	18.Mot	her's Name (		, Maider	n Surname)	it A	irlines
MD 21, 12 should b th and Men 127 is maric umartic eve	٥[	19a. Informant's Na Luna K.	ame/Relations Nowver			- 1			Street and N	Number or Ru	ral Route N	umber, (	City or Towr	2070	8
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		_		n 3 Removal	from State	cremato	ory or other and 1	er place) Vat 1	of cemetery, Mem	07/3	Date 31/201	2 I	aure]	, M	Гоwn, State
Balti permit. Departm Importi		21. Signafure of Fu	uneral Service	Licemee	rde )	D.	246	5 N. V	Vashin	gton S	t, Ro	ckvi	lle,	MD	20850
Physician IMedical Examiner		23a, Part I, Enter the failure. List or Immediate Cause or condition resulti	nly one cause (Final disease	on each line. a. <b>Diabet</b>		acid		e mode of d	ying, such a	s cardiac or	espiratory a	irrest, sh	ock, or hea	nrt	Approximate Interval Between Onset and Death
	aminer	Sequentially list co if any, leading to in cause. Enter Under	mmediate erlying Cause		a consequence	of):									
ecuted and transit	ă۱	(Disease or injury events resulting in	death) Last	d	a consequence			000 0	0.10						
760, icate be exphysician the burial	Medic	IF FEMALE: 23b. Was decedent		23c. If yes	23a, 27,							23	3d. Date of		
Box 68760, e death certificate by the attending physic ed for use as the burner.	Physician/Medical	past 12 months	s?	4 Pre	birth gnant at time of one nown	death 5		al death er (Specify,		opic pregnan	су 		Month	D	ay Year
P.O.	ব	Part II. Other sign	ificant condit	tions contributing	to death but not	t resulting	in the un	iderlying ca	use given in	Part I.		_	_	_	he cause of death?
Records, P.O. The law requires that the fieare has been signed by Figure 2 should be deaded.	Completed		_									opsy form <u>ed</u> ?	pi d		opsy findings available ompletion of cause of
R. T. Truiffice, par, par	اق	25. Was case refer	rred to medica	al				26.1	Place of Dea	ath (Check or				-	

Be

examiner?

1 🗸 Yes

27. Manner of Death 1 🗶 Natural

Accident

2-PEND

Division of Vital R
To the Hospital or Attending Physician: T
within 24 hours after death.
To the Funeral Director: After this certifical
completely filled in by the funeral director, p Certification: To 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 18, 2012

28a. Date of Injury (Month, Day,Year)

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 2 6 2012

32. Registrar's Sign sture

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other Nursing Home 5 Residence 6 🗹 Other: Scene

28d. Describe how injury occurred

State Registrar

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JuMogth 2012 3:15 A<sub>M</sub> Pay, Mullin Jeannie Maxine Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Washington **Examiner** 4b. City, Town, or Location of Death Homewood Retirement Center Williamsport Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗚 Days Hours June 28,1916 Corntry) 521-12-6837 **Director** 96 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Williamsport 1 Yes 2 No Maryland Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21795 16505 Virginia Avenue Cottage 134 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc 1 Never Married 2 Married ģ Yes, Give X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alta Leona Palmer Albert Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Crispin Lane Falling Waters, West Virginia 25419 Donald R. Mullin-Son injury or other tem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it nent of 1 Burial 2 X Cremation 3 Removal from State Hagerstown Crematory | July 16,2012 | Hagerstown, Maryland 4 Denation 5 Other (S 22. Name and Address of Facility Osborne Funeral Home, P.A. nature of Funeral Ser any 425 S. Conococheague St.Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUKUMIA Physician/ HUNK disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 4 Pregnant Pregnant at time of death Year 1 Yes 2 No 9 Unknown ed by the a signed b Part i. Other significant conditions combibuting to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 24a Was an page 2 autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accident 5 Pending s after death. 1 Yes 2 No Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Exam basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat ertifie

Box 68760

P.O.

Records,

Division of Vital

State

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IRA EUGENE MOORE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Med. Ctr. Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 557-50-2917 Director 1 □ M 2 □ F 74 07/31/1937 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director WV Mineral Mineral Ridgeley 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 26753 U.S.A. R.R. 3, Box 350 death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 1 ☐ Yes 2X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Hospital injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or one. ည Wilma V. Grenaway Ira A. Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R.R. 3, Box 350, Ridgeley, WV 26753 Irene Moore / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Fort Ashby Cemetery 07/13/2012 Fort Ashby, WV 22. Name and Address of Facility Upchurch Funeral P.O. Box 1260, Fort Ashby, WV . Signature of Funeral Service Licen, ee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ARDIAC disease or condition resulting in death) MIN Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician; The law requires that the death certificate be executed and I-tran Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 Yes 2 No Yes the Funeral Director: After this certific npletely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 🗹 No 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending death. Accident Investigation 2 Accider
3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature of certifier Name and address of person who comnds

2

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Lillian Mitchell 2012 Susan Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany Western MD Regional Medical Center Cumberland 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Director 219-74-6662 1 □ M 2 🏋 F 64 07/26/1947 Maryland Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director must be notified 1 Yes 2 X No Cumberland MD Allegany 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö 23a Funeral USA 21502 11907 Bayberry Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) the Disabled None traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file h and Mental ? **7 is marked o** Mitchell Charles Reese ပ Lillian 19a. Informant's Name/Relationship (Type, Print)
Joanna Evans / Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Springwood Drive, New Freedom, PA 17349 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Crematory 07/06/2012 20c. Location - City or Town, State permit. Page 1 a Important: If it any injury or o once. 1 Bunal 2X Cremation 3 Removal from State Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. Sign ture of Funeral Service Lice 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No signed by the atter Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISORNER 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation filled in by the Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

29b. Signature and title of certi-

Shiv 31. Date filed (Month, Day, Year)
JUL 0 5 2012 32. Registrar's Signature backs

Registrar

address of person who completed cause of death (Item 23a) (Type, Print) niv C. Khanna, M.D., 1221-E National Highway, LaVale, MD

29c. License number

29d. Date signed (Month, Day, Year)

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MILLER 20 PM LUELL DIC 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Lions The Center Cumberland 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6 Sex **Funeral** Min (Month, Day, Year) Director 217-10-4700 1 🗆 M 2 🗷 F MD 12-29-1916 or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Allegani Cumberland 1 Yes 2 No MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral Drive 901 Seton USA 21502 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 M No 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 No Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Store Clerk 12 Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Malden Surname) ပ္ STOUFFER LEYDIG BERTIE OSCAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3/529 13108 Twin Maples DR. PoBox 159 Ellerslie MD Department of Health a Important: If item 27 is any injury or other trains 1 DGH CAROLYN MASON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 1 Burial 2 Cremation 3 Removal from State 7-5-2012 Buffello Mills PA BARGER CEM. 4 Donation 5 Other (Specify) 22. Name and Address of Facility HARVEY H. ZEIGLER F.H. INC Signature of Funeral Service License 169 Clarence ST HYNDMAN PA Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 23a. Part 1 Interval Between
Onset and Death
2-years Immediate Cause (Final Physician Atheroscleroti disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed as the burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year the 9 Unknown P.O. I signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hospital or Attending Physician: The law requires to thours after death.
Funeral Director: After this certificate has been sign Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4月 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ဂ္ 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier mockshi 00055325 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 128 Rd (umberlund Bishop Walsh 925

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Mpp) Day Year) 2012

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Virginia Meekins Carolyn 0:05A Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4h City Town, or Location of Death **Examiner** Allegany Center Cumberland Western MD Regional Medical If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Months Hours Min (Month, Day, Year) 06/09/1950 **Director** 219-54-1567 1 🗆 M 2 💢 F Maryland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No Allegany Cumberland MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21502 USA 118 Independence Street death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian n. Page 1 and 2 should be filed within 72 hours after deartment of health and Mental Hygiene. Black, White, etc. þ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary State Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) McDonald ပ Herman Meekins, Sr. Dorothy Dalton Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r. 434 Pine Avenue, Cumberland, MD 21502 Herman M. Meekins, Jr. / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗶 Burial 2 🗌 Cremation 3 🗆 Removal from State Department of Important: If any injury or Sunset Memorial Park 07/09/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Alams Family Funeral Home, P.A. Si nature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 23a. Part 1. Buter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Physician! disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Junto for an a consequence of cause. Enter Underlying Cause (Disease or injury and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page perform 1 Yes 2 No Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) DO018216

Registrar

DHMH 17 Rev 06-2011

State

MK

Marke

12501 Willowbrook Road, Cumberland, MD

21502

address of person who completed cause of death (Item 23a) (Type, Print)

strar's Signature

Steven Smith, M.D.,

ear 0 9 201

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland / Der		Mental Hygien	e 2012 24351
			State Registrar	Ce	ertificate of Death	Reg. I	No.
	Physicia Medic		1. Decedent's Name (First, Middle, Last) William	Bernard	McCarthy	2. Date of Death Month	Day Year 3. Time of Death 18.55 M
	Examin		4a. Facility Name (if not institution, give str Western MD Region:	,	4b. City, Town, or Location of Dea Cumberland	ith 4	4c. County of Death Allegany
k'	Funeral Director			7. Age (In yrs. last birthday M 2 $\square$ F 76 Yrs.	Months Days Hours Mir		9. Birthplace (State or Foreign Country) Maryland
	f show	tor	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or I	ocation		10d. Inside City Limits
	the Man or 28a-	Direc	MD Alle,	27	umberland	10g.	1 ☐ Yes 2 🗶 No  Citizen of What Country?
	ms 23a must b	Funeral Director	12903 Memory Lan	-	21502	Specify Vos or No.	USA
920	rs after dea ıral", or ite Examiner		11. Marital Status  1 □ Never Married 2 □ Married  3 Ⅸ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	i. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue 1 Pyes 2 X No Specify:	rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+) (Giv	edent's Usual Occupation e kind of work done during most of w DO NOT use retired) Roofer	orking	. Kind of Business/Industry
and 5	be filed wit ental Hygle <b>ked other</b> ic event, the	l ou l	17. Father's Name (First, Middle, Last) Oscar Bern	ard McCartl	ny 18. Mother's N	ame (First, Middle, Maide May	
Mary	d 2 should alth and Ma 127 is mar er traumati		19a. Informant's Name/Relationship (Type Brenda L. Festerma	n / Daughter 19b. Ma	iling Address (Street and Number or F 5 Cranberry Sprin	Rural Route Number, City gs Road, Fr	or Town, State, Zip Code) ostburg, MD 21532
imore,	Page 1 and nent of Hea ant: If item ary or othe		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	Restlaw	ematory or other place) n Mem. Gardens 07	/17/2012	LaVale, MD
Balti	permit. Page 1: Department of h Important: If its any injury or of	İ	21. Sign it is e of Funeral Service Vicensee	1000	404 Decatur Stre	et, Cumberl	Funeral Home, F.A. and, MD 21502
_ f	nysician/		23a. Part 1 Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.  Acute_ Ren	nter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequence of):	ion		
	ed sit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
_	ate be executed shysician and the burlal-transit	dical Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
760	cate b	edic	d.				
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnancy  1	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
s, P.O.	ires that the signed by I Id be detacl	by	Part II. Other significant conditions cont		e underlying cause given in Part I.		o use contribute to the cause of death?
Division of Vital Records,	<b>sician:</b> The law requ certificate has beer lirector, page 2 shou	Completed				24a. Was an autopsy performed? 1 \(\sum \) Yes 2	
tal	ician: T sertifica rector, p	Be	25. Was case referred to medical examiner?	spital:	26. Place of Death (Ch	eck only one)	
of V	ng Phys fter this ineral di	rte: To	1 Yes 2 No	28a. Date of injury (Month, Day, Year)  Performance of ER/Outpat 28b. Time injury	ient 3 □ DOA   4 □ Nursing of 28c. Injury at	Home 5 Residence 28d. Describe how inj	
vision	To the Hospital or Attending Physiciam: Within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Certificate:	2  Accident Investigation 3  Suicide 6  Could not be 4  Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, ate)
۵	Hospital of the hours a subsection of the hours a subsection of the hospital o	Medical C	29a. Certifier 1 Pertifying Physic (Check 2 Medical Examine	ian: To the best of my knowledge, deat r: On the basis of examination and/or inv	h occurred at the time, date and place estigation, in my opinion, death occurre	e, and due to the cause(side at the time, date and pla	) and manner as stated. ice, and due to the cause(s) and manner stated.
	To the I within 2 To the F complet	Me	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the best of my knowled		place, and due to the cau	
0	5 mel		30. Name and address of person who cor		D00718	57 7	114/2012
			AMIT BHANDA	RI 12500 W	ILLOWBROOK PL	, CUMBR	MAN, MD 21502
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 16 ZU12	32. Registrar's Signature			

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

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29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

July 12, 2012

<sup>"</sup>2012

wo

30. Name and address of person who completed cause of death (item 23a)

Assistant Medical Examiner

Registrar's Signa

29b. Signature and title of certifier

Laron Locke MD.

31. Date filed (Month, Day

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3, Time of Death Month Day Physician/ Tommie Т. Moss Ju<sub>1</sub>y 2012 5:16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Healthcare at Asbury Methodist Village Gaithersburg Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month | Day, | Dec . 10, 9. Birthplace (State or Foreign Country) GA 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** <sup>Year</sup> 1928 1 🗆 M 2 🖾 F 83 400-34-6180 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Montgomery Chevy Chase 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 20815 USA 4601 N. Park Avenue, Apt. 1021 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married Completed by Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Supervisor Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Madge Smith မ Mel Moss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
943 Bonifant Street, Silver Spring, MD 20910 19a. Informant's Name/Relationship (Type, Print) Frank J. Marcellino/Personal Rep 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date July 14, 2012 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA F2 lancing Address continuous Funeral Home Inc. 500 University Blvd. W. Silver Spring,MD 20901 21. Signature of Funeral Service Licenses 23a. Party Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ Tertrochanterich disease or condition Medical resulting in death) **Examiner** Figure 1 in the second of the Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial-3 attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the been signed by the attending post-should be detached for use as IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗹 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 performed Yes 2 Severe dementes 1 Yes 2 No 25. Was case referred to medi examiner? 1 ☑ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 ☐ Matural 2 ☑ Accident 5  $\square$  Pending Mechanicalpa 2 🖪 No Investigation Suicide Could not be 28e. Place of Figury - At home, farm, street, factory, office 28f. Location (Street and Num er or Fural Route Number, City or Town, State) 97/3 Inducay Chal Warf Mutymers V. L. Je M. 20. 4 Homicide determined (Specify) building, etc. Sercep Hon Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner of stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 04115

State Registrar 31. Date filed (Month, Day, Year)

CATHERSBURG WIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/RUSSLL 4 VENUE

2. Registrar's Signa

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-		State of Maryland / Dep	artment of Health and I	Mental Hygie	ene J. No. 2012	24354
п	Physicia	ın/	Decedent's Name (First, Middle, Last)     Paul A. McDonald		2. Date of Death  July 12,	Day 2012 Year	3. Time of Death 9:53 aM
and a	Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	9:53 am
-			Medstar Montgomery Medical Center	Olney		Montgom	ery
	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  578−34−7611  MX M 2 □ F  OR  Vrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	g. Birthp ear) Count	lace (State or Foreign ry)
			Usual Residence of Decedent 82		Dec. 7,	1929 Washi	ngton, DC
	ryland I-f sho ied at	Director	10a. State 10b. County 10c. City, Town or Lo			10	0d. Inside City Limits
	he Ma or 28a o notif		MD Montgomery Silve	er Spring  10f. Zip Code	100	g. Citizen of What Count	1 Yes 2 No
	with t	Funeral	14607 Deerhurst Terrace	20906	109	USA	19:
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
21215-0036	rs after ral", o Exam	ed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1954–56	1 ☐ Yes 2 🔀 No Specify:		Specify: Whit	
2-0	2 hour "natu edical	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of work	ina 16	b. Kind of Business/Ind	ustry
121	iled within 72 Il Hygiene. other than '	Com	Elementary/Secondary (0-12) College (1-4 or 5+) life. D	O NOT use retired)  Les Executive	9	Technology	
д 2	filed w al Hygi d other went, 1	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maid	den Sumame)	
Maryland	should be fill n and Mental 7 is marked o raumatic eve	မ	Herbert J. McDonald	Elizal	oeth M. Di	illon	
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			ng Address (Street and Number or Rur 7 Deerhurst Terrac	al Route Number, Cit	ty or Town, State, Zip Co Spring, M	D 20906
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or otl				11 7 17 .	c. Location - City or Tov Silver Spri	
Ball	permit Depart Import any inj		21. Signature of Funeral Service Licensee	rancis Adjess Coillins 00 University Blvd	Funeral H l. W, Silv	Home Inc. ver Spring,	MD 20901
	hysician/	ec 0	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Pneumonia	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate - Interval Between Onset and Death
	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate b. Emphysema  b. Due to (or as a consequence of):				
	nted nted	Examiner	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events  C.				
	te be executed lysician and he burial vizate	ical Ex	resulting in death) Last Due to (or as a consequence of):				
760	cate b physi		d				
P.O. Box 6876	eath certiff attending d for use a			Ectopic pregnancy Other (specify)		23d. Date of deliver	ry Day Year
О.	it the d I by the etache	Phys	g Unknown  9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the unknown	and and the control of the control o			
ds, P.	quires tha	ted by	Atrial Fibrillation	indenying cause given in Part I.		co use contribute to the	
Secor	The law re tte has be bage 2 sh	omple			24a. Was an autopsy performed 1 Yes 2	prior to com death?	sy findings available inpletion of cause of
ta	cian:   ertifica ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check		* NO TES Z	140
<u> </u>	Physic this c	မ	1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatier  27. Manner of Death 28a. Date of Injury 28b. Time of			e 6 Other (Specify)	
o uc	nding ath. :: After e fune	icate	1 🛣 Natural 5 Dending (Month, Day, Year) injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Division of Vital Records,	cal or Attending Pl s after death. Il Director: After the ed in by the funera	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)		28f. Location (Street City or Town, St	t and Number or Rural F tate)	Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed with the Abours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transfer.	Medical	29a. Certifier (Check conly one)  1	igation, in my opinion, death occurred at	the time, date and pl	lace, and due to the caus	se(s) and manner stated.
	To With	-	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Da	ay, Year)
	16		30. Name and address of person who completed cause of death (Item 23a) (Type, F	D006313 6	s	July 12	5015
			Richard Mahon, MD 18111 Prince P	hilip Drive, Olne	y, MD 208	32	
	Stat Registra	-	31. Date filed (Month, Day, Year)  JUL 13 2012  2. Registrar's Signature  B. Agar	W.			

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	•	For State Registrar	rica	State			d / Depa		t of H	ealth		lental Hy		e 2 (	112	24	355
Physicia		Decedent's Name (First, Midple, Last)						94 S	2. Date of							3. Time of t	
Medic Examin		4a. Facility Name (if not institution, give street and number)  Mandrin House						- / /	Town, or Location of Death Harwood				4c. County of Death Anne Arunde1				
Funeral Director		5. Social Security N 225-03-22 Usual Residence	285	6. Sex 1 □ M 2 <b>X</b>		(In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Year)		9. Birthp Count	lace (State or ry) VA	Foreign
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fiutry or other traumatic event, the Medical Examiner must be notified at ance.	Funeral Director	10a. State MD	10b. County Ann	ne Arund		10c. City,	Town or Loc		nton						10	0d. Inside City	
	eral D	10e. Street and Nur 1245 St.		Lane				10f. Zip		1113		!	10g. C		What Count	ry?	
	ρ	11. Marital Status 1 ☐ Never Man 3 <b>XX</b> Widowed		ed 1 7 If Yes,	ecedent Eve Forces? es 전図 N Give Dates.		11	Vas Deced Yes, spec	ify Cubar	n, Mexicar	n, Puerto	cify Yes or No Rican, etc.)	-		e - America ck, White, e Wh		
within 72 hou giene. <b>er than "nat</b> u t <b>the Medi</b> cal	Completed	(Spe Elementary/Sec 10	, , ,	t grade complet	ed) e (1-4 or 5+)	)	life. Do	lent's Usua kind of wor O NOT use emake	k done d retired)		t of worki	ing	16b.		usiness/Ind	•	
d be filed Jental Hyg Irked oth	To Be	17. Father's Name (			1							e (First, Middle Rachel			e)		
d 2 should all the and N 27 is ma		19a. Informant's Na Gary May		ip (Type, Print) SOT	ı			g Address Franc				inore,				ode)	
Page 1 an nent of He int: If iten iry or othe				3 ☐ Removal fr	om State	ce	nce of Dispo metery, cren n Have	natory or o	ther place			Date 2/2012			City or To		
permit. Departn Importa any Inju		21. Signature of Fu	neral Servige Li	censee							tMard	lesty F apolis	uner	al H	ome,		
Physician/ Medical	ler	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a															
Examiner		Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):							1	ar	Xen	7 8	es	aar	1	yea	~
be executed sician and burial-transit	cal Examiner	cause. Enter Unde Cause (Disease or that initiated event resulting in death)	ertying injury ts	c	C												
tificate bong physic		IF FEMALE:		d									1	-			
To the Hospital or Attending Physician: The law requires that the death certificate it within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1							oregnanc ecify)	у	23d. Date of delivery  Month Day					•	ear
requires that the de- been signed by the s should be detached	ē	Part II. Other significant conditions contributing to death but not resulting in the							ving cause given in Part I. 23e. Did tobacco use contribute to  1 ☐ Yes 2 ☐ No 3 ☐ F								
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tal or Atters after degral Director	Il Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could r determi	28e. Pl						28f. Location (Street and Number or Rural Route Number, City or Town, State)				er,			
he Hospit in 24 hour he Funera ipietely fills	Medical	(Check 2	2 🔲 Medical E	Physician: To the kaminer: On the Nurse Practitio	basis of exa	amination	and/or invest	tigation, in	my opinio	n, death o	ccurred at	the time, date	and plac	e, and du	e to the cau	se(s) and man	nner stated.
NX.		29b. Signature and	title of dertifier	12	fale		by m	290	License	number	8	4	29d. D.	ate signe	d (Month, E	ay, Year) 2012	,
\$ 15		NICHA	a J	vho completed o	ause of dea	ath (Item 2	23a) (Type, F 441	Print)	EYE	NS	EHa	y ANI	VAF	OCS	MD	2140/	
Stat Registra		31. Date filed (Mon	th, Day, Year)	2012	2. Registrar	's Signatu	d.	bones	1			,			-		
AH 17 Pov 06-3	2011				77.												

Please Type or Print in Black Indelible Inka Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 2230 Lawrence E. Montaque Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Month, Day, 1 nr 28 **Funeral** D.C. Days Hours 214-50-8416 1**X** M 2 □ F Apr 1948 Director 64 Yrs. Usual Residence of Decedent 28a-f show 10d Inside City Limits ms 23a or 28a-f shor must be notified at 10a. State 10c. City, Town or Location Maryland Anne Arundel Annapolis 1 Yes 2X No 늅 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 USA 1007 Monroe St. items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 0 1 Never Married 2X Married þ 1 ☐ Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. 27 is marked other than "natural", traumatic event, the Medical Exal Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 (al Hygiene. College (1-4 or 5+)  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 10\,th \end{array}$ PetSmart Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I 2 Essie Thompson George E. Montague 1 and 2 should bot Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1140 Madison St. Apt A3 Annapolis, Md. 21403 Gloria Montague(Wife) 20a. Method of Disposition
1 

Burial 2 Cremation 3 

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 7-16-12 Metro Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Winname Remember of Secilitisons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Lance -Physician · Day disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, rany, reading to immediate cause. Enter Underlying Examiner Due to for self-transactions on Cause (Disease or injury tran and that initiated events resulting in death) Last Due to (or as a consequence of): use as the burialthe attending physician Physician/Medical certificate be P.O. Box 68760 /es, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death detached g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 Director: After this certificate has performed Yes 2 No death? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) 2/0/15 D475715 son who completed cause of death (Item 23a) (Type, Print) Ann-RUN Midich

Registrar DHMH 17 Rev 06-2011

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ MORRIS onald 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Georges ring Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min. 80-4769 **Director** M 2 □ F 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No Maryland George handover 10f. Zip Code 10g. Citizen of What Country? Funeral 2406 20785 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 **X** No Yes Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Completed 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 00 sevel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gray 20613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ RemovaLfrom State Naldorl √ Other (Specify) 20608 Name and Address of Facility MI Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Exami signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? completely filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performe 1 Yes 2 X No Yes Hospital or Attendir g Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: injury 1 🔀 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifi who completed cause of death (Item 23a) (Type, Print) State Registrar

12-05071 Corinda Moore Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 24358 State of Maryland / Department of Health and Mental Hygiene

	-	- For State Registrar			Certifica	ate of	Death			Reg. N	0.		
Physicia		Decedent's Name (First, Midd)	First, Middle,Last)  2. Date of Death Month Day								/ Year		. Time of Death
ledical Examir		Corinda M.	Moore							6, 2012			1155 hrs
		4a. Facility Name (if not institution	_			4	b. City, Town, or L	ocation of De	eath	ľ	4c. County of		
		Naylor Mill Road and	Salisbury Byp	ass			Salisbury				Wicomic		
Funeral		5. Social Security Number	6. Sex	7. Age (	In yrs. last birt	hday)	If Under 1 Year  Months Days	If Under 24 Hours	4Hrs. 8. Dat Min.	e of Birth(MI	M/DD/YYYY)	Foreign	place (State or
Director		219-07-7694	1 M 2X F	89		Yrs.	Months Days	liouis	07,	/01/19	923	Count	Maryland
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Aaryland 28a-f show 1 at once.	Director	10e. Street and Number					10f. Zip Code			10g. C	itizen of Wh	at Country	y?
th the Maryland 23a or 28a-f sho notified at once.	ä	22102 Royal O	ak Road				21856	, )			USA		
5-0036 led within 72 hours after death with the Maryland Jygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	ᅙ	11. Marital Status	12. Was D	ecedent Ev	er in U.S.		Decedent of Hisp	anic Origin?			14. Race White		n Indian, Black,
eath riten	Funera	1 Never Married 2 M	larried Armed	Forces?	No	l if te	es, specify Cuban,	Mexican, Fu	Jeno Rican, e	nc.)	VVIIIC	, 010.	
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ours a	d b	15. Decedent's Education (Spe		rade compl			's Usual Occupations of working life. I			e 16b	. Kind of Bus	siness/Ind	lustry
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5-00 iled with Hygien d other		17. Father's Name (First, Middle	e, Last)						lame (First, N		en Surname)		
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Physician		23a. Part I. Enter the disease, o failure. List only one cause	r complications that e on each line.	t caused th	e death. Do n	ot enter th	ne mode of dying, s	such as card	lac or respira	itory arrest, s	snock, or nea	iπ	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease	Multiple I	njuries									Death
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687 ertific ding 1		23b. Was decedent pregnant in past 12 months?	'     '	e birth				Ectopic pr	regnancy		Month	Day	y Year
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that the ned by detach	þ	•							1	Yes 2	<b>√</b> No 3[	Probal	bly 4 Unknown
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Hos 24 ho Fun etely		29a. Certifier 1 Certifying	Physician: To the	best of my	knowledge, de	eath occur	rred at the time, da	ite and place	e, and due to	the cause(s)	and manner	as stated	d.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		caminer: On the ba		ination and/or	investiga			neu at the th				
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		Melle Bu	and No	13			O.C.M	VI.E.		l J	uly 7, 201	2	
INTER		30. Name and address of person											
40		Melissa Brassell, MD				900 V	V. Baltimore S	treet, Balt	timore, MI	21223			
S	tate	31. Date filed (Month, Day, Yea		. Registrar	s Sign dure	Lak	U						
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			For State	State of Ma	aryland	•		Health and	Mental Hy	/giene	001	0	24359	2
			Registrar  1. Decedent's Name (First, Middle, Las	·+1		Cei	rtificate of	Death	T	Reg. No	1 U S.c	4		)
	Physicia		Marie Esther M	•					2. Date of De Month	eath Da	2017	/ear	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give				4b. City, Town, o	or Location of Death	h		c. County of		חרט, ן	$\dashv$
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	Funeral Director		Social Security Number     Security Number     Security Number	ex 7. Age	Age (In yrs. last birthday)  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.				8. Date of Bi				place (State or Foreign	
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8	ture!"	Completed by	3 √ Widowed 4 □ Divorced	If Yes, Give Year or Dates.			1 ☐ Yes 2 ☑ No			,	Specify:	Whi	te	
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ē,	t of Heelt or other		Kenneth McGrath 20a. Method of Disposition	/son	20b. Pla	ace of Dispo	osition (Name of	rrace,	Cambrio Date		, MD .ocation - Ci			$\dashv$
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filad within 72 hours efter death with the Maryland Department of Heelih and Mental Hyglene. Importent: If Item 27 is marked other then "neturel", or Itams 23e or 28a-f show eny Injury or other treumetic avent, the Modeal Examinar must be notified at once.		21. Signature of Funeral Service Licens	··	, IMD	Veter 2	2 Name and Adder	nce of Engility	2012		rloc		. <u>D</u>	-
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0	ttending Phy daath. dor: After this y the funeral o	ate:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	ry 2	28b. Time of injury	f 28c. Injur worl	ry at rk?	28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
#OH	trendii daath. dor: A the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		117		M 1□	Yes 2 □ No						
Ni≥	after Direc	Se	4  Homicide determined	28e. Place of Injui building, etc.			eet, factory, omce		28f. Location ( City or To			r Rural	Route Number,	
<u>.</u>	To the Hospital or Atterview within 24 hours after day To the Funeral Director Completely fill of in by the	edical	29a. Certifier Certifying Phys	sician: To the best of r	my knowle	edge, death	occurred at the tim	ne, date and place,	and due to the c	ause(s) a	and manner	as state	ed.	$\dashv$
	he Ho nin 24 the Fu hplete	Med	(Check 2   Medical Examination only one) 2   Certifying Nurs	ner: On the basis of ex se Practitioner: To the	xamination a	and/or inves	tigation, in my opini	ion, death occurred a	at the time, date a	and place	e, and due to	the cau	use(s) and manner state	d.
·			29b. Signature and title of certifier				29c. Licens			29d. Dat	ite signed (M	fonth, E	Day, Year)	
	3							05841	0	0	1/11	1/1	<u></u>	
			30. Name and address of person who c				III.	h-1 nd	Coli	~ lass 2	M	D 3	21801	
	Stat	e	Dr. Ghulam War 31. Date filed (Month, Day, Year)	32. Registra			d HOSDI	rai Ro.	, Sall:	SDUI	cy, M	<u>U_4</u>	,1001	$\dashv$
	Registre		4 7 7	/III// K76	44.4	A A								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For	ertificate of Death		Reg. No.				
П	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Year	3. Time of Death			
	Medic	al	Jeannette Leighton Novak  4a. Facility Name (if not institution, give street and number)	4). Cit. Town and position of Dooth	July	11, 2012	12:20 A M			
	Examin	er	4a. Facility Name (it not institution, give street and number)  Bedford Court	4b. City, Town, or Location of Death Silver Sprin		4c. County of Death Montgome				
1	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthda)		8. Date of Birth	9. Birt	hplace (State or Foreign			
	Director		019-12-7922 1 □ M 2 🖾 F 98 Yrs.	APRIL	18,1914 CALIFORNIA					
	ind show at	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10								
	//aryla 8a-f s tified	Director	MD. MONTGOMERY	SILVER SPRING			1 🏋 Yes 2 □ No			
	a or 2 be no	ΪΩ	10e. Street and Number	10f, Zip Code		10g. Citizen of What Co	untry?			
	th with ms 23 must	Funeral	3700 INTERNATIONAL DR. #122	20906	:6 - V # N	U.S.A.				
<b>'</b> 0	or iter	by Fu	11. Marital Status  1. Was Decedent Ever in U.S. Armed Forces? 1. □ Never Married 2 □ Married 11. Was Decedent Ever in U.S. Armed Forces? 1. □ Yes 2 ☑ No	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	14. Race - Ame Black, White				
036	rs afte iral", ( Exan	ed b	3 XWidowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:		Specify: WI	HITE			
5-0	2 hou "natu	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work	king	16b. Kind of Business	Industry			
121	ithin 7 ene. • than he Mo	Som	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired) HOMEMAKER		HOMI	F.			
d 2	lled will Hygid other	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle,	Maiden Sumame)				
/lan	d be fi	임	GRANVILLE W. LEIGHTON	F	RANCES	MOSHIER				
Maryland 21215-0036	shoulk and N is ma		19a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number or Rui						
	and 2 s Health tem 27		SUSAN C. QUILLIAN/NIECE 923 20a. Method of Disposition 20b. Place of Dis	4 13th AVE. N.W.	, BRADEN	NTON, FL. 34				
nor	nt of h		1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State cemetery, of	rematory or other place)		•				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		CHILIDE		1-2012	RIVERDAL				
m	Depar Impor any ir		Manuelle M00091	22. Name and Address of Facility CHAMBERS FUNERAL H 5801 CLEVELAND AVE	OME & CI RIVER	REMATORIUM,	20737			
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	or respiratory arr	rest,	Approximate Interval Between				
-	Hysician/		Immediate Cause (Final disease or condition resulting in death)		Onset and Death MONTHS					
ing megan	Medical Examiner		Due to (or as a consequence or).				YEARS			
		ner	Sequentially list conditions, if any, leading to immediate b. SENILITY  Due to (or as a consequence of):			20	ILANS			
	ord ord	cami	cause, Enter underlying Cause (Disease or iinjury that initiated events  c.							
	icate be executed physician and sthe burburans	Medical Examiner	resulting in death) Last Due to (or as a consequence of):							
200	cate b physic	edic	d							
89	certifi anding use as	In/M	IF FEMALE: 23c. If yes, outcome of pregnancy   1	3 ☐ Ectopic pregnancy		23d. Date of de	livery			
Вох	death certif he attending ed for use a	Physician/N	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year			
P.O.	at the d by the etach	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?			
	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burbusers!	d by			1 🗆 '	Yes 2 No 3 P	robably 4 XUnknown			
ord	v requ	Completed			24a. Was		topsy findings available			
<b>3ec</b>	The law cate has page 2:	mo			autor perfo 1  Yes	rmed? death?	s 2 No			
E	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Che	ck only one)					
ί	Physia this c	은	1 Yes 2 XNo 1 Inpatient 2 ER/Outpa 27. Manner of Death 28a. Date of injury 28b. Time			dence 6 Other (Spec	ify)			
o u	Attending Physician: # death. ector: After this certific by the funeral director,	cate	1 X Natural 5 ☐ Pending (Month, Day, Year) injur 2 ☐ Accident Investigation		200. Describe n	low injury occurred				
Division of Vital Records,	r Atter er deg rector by the	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	Street and Number or Ru	ral Route Number,			
ă	oital o urs aff ral Di									
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director After this certific Topideted filled in by the funeral director.	Medical	29a. Certifier  1 Certifying Physician: To the best of my knowledge, dea (Check only one)  2 Medical Examiner: On the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of my knowledge.	vestigation, in my opinion, death occurred	at the time, date a	ind place, and due to the	cause(s) and manner stated.			
	To the Some	2	29b. Signature and title of christien	29c. License number		29d. Date signed (Monti				
	le		) July	D38457		JULY 11	, 2012			
			30. Name and address of person who completed cause of death (Item 23a) (Typ		QUITE A	11 07777	20906			
	Sta	te.	DR. NAKUL GOYAL, M.D. 3801  31. Date filed (Month, Day, Year)  32. Registrar's Signature	INTERNATIONAL DR.	SUITE 2	11, SILVER	SPRING, MD.			
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	arket.						

Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

		For State	Pleas	se Type or State o	<b>Print in</b> of Marylar	nd / Dep	artment	of H	ealth		•		•	gible.	01061
Physicia Medio		Registrar  1. Decedent's Name		Last) Gregory	NUTTER		rtificate	of D	eath		2. Date of D	Reg. I	Day	2 <sup>Year</sup> 17	3. Time of Death A Z 6: ZO M
Examin		4a. Facility Name (if I			mber)		4b. City, To			of Death	(		4c. Count Wash		
Funeral Director		5. Social Security Nu 217-56-10  Usual Residence o	609	3. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs.	ast birthday) 51 Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D <b>Feb</b> •	av. Year	951	Cot	hplace (State or Foreign untry) yland
a-f shov ified at	Director	10a. State Maryland	10b. County Washin	gton		ty, Town or Lo							_		10d. Inside City Limits 1 ☐ Yes 2X No
23a or 28 st be not	eral Dir	10e. Street and Num 6811 Tomr		Road			10f. Zip (		1782			10g.	Citizen of What Country?		•
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1  Never Marrie 3  Widowed 4		Armed Fo	2 🔀 No ve	S. 13.	Was Deceder If Yes, specification 1 Yes 2	y Cuban	, Mexica	n, Puerto	cify Yes or No Rican, etc.)	)-	Bla	14. Race - American Indian, Black, White, etc.  Specify: white	
giene. er than "natu the Medical	Completed	(Special Special Speci		's Education t grade completed, College (1		(Give	dent's Usual kind of work DO NOT use r ection	done du etired)	ıring mos						Industry Maryland
ental Hyg ked othe ic event,	To Be	17. Father's Name (F		st) Nutter		18. Mother's Name (						e, Maide	n Surnam		
h and Mi		19a. Informant's Nar Sharon Nu	me/Relationshi	o (Type, Print)			Madeline ing Address (Street and Number or Rural Route Numb Tommy Town Road, Sharps						or Town,		•
nent of Healt Int: If item 2 Iry or other		20a. Method of Disp	osition Cremation	3 ☐ Removal from	State	Place of Disp cemetery, cre gersto	osition (Name matory or oth	of er place	)		Snarps Date 2012	20c.	Location	- City or	Town, State  Maryland
Departn Imports any inju once,		21. Signature of Fun	neral Service Lic	ensee	<u> </u>		2. Name and			ty M	innich	Fur	neral	Hom	
ysician/ Medical kaminer		23a. Part 1. Enter th shock, or hearl Immediate Cause (F disease or condition resulting in death)	t failure. List on Final	omplications that ly one cause or a.  Due to	caused the deat ach line. Yellon (or as a conseq					cardiac c			da	ãc	Approximate Interval Between Onset and Death
attending physician and I for use as the burial-transit	dical Examiner	Sequentially list con if any, leading to imicause. Enter Underl Cause (Disease or ii that initiated events resulting in death) L	mediate lying njury	с	(or as a conseq										
the attending p ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 🔲 Live	tcome of pregna Birth 2  Feta gnant at time of nown	al death 3	Ectopic pre							ate of deli onth	very Day Year
is certificate has been signed by the a director, page 2 should be detached	by	Part II. Other signific		s contributing to d				use give	en in Part	I.					the cause of death?
ficate has be or, page 2 sh	Completed	25. Was case referre	Kriste	una			•	00 51			1 Yes	opsy formed?	,	prior to c death?	opsy findings available ompletion of cause of
is certii I directo	To Be	examiner?		Hospital:	Inpatient 2	ER/Outpatie	nt 3 🗆 DOA	Othor			only one) me 5 $\square$ Res	idence	6 🗆 Oth	ier (Speci	fy)
ath. r: After th ne funeral	Certificate:	27. Manner of Death  1 X Natural 2 Accident	5 Pending Investiga	ition	of injury eth, Day, Year)	28b. Time o injury	M .280	: Injury a work? 1 \Boxed Y			28d. Describe	how inj	ury occuri	red	
irs after de al Directo led in by th		3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ed 28e. Place	of Injury - At hoing, etc. (Specify		eet, factory, o	office			28f. Location City or To			er or Run	al Route Number,
within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 (Check 2 only one) 3	☐ Medical EX.	Physician: To the base in the	sis of examinatio	n and/or inves	tigation, in my , death occuri	opinion ed at the	, death o	ccurred at	the time, date	and pla the cau	ce, and du se(s) and r	ue to the c manner as	ause(s) and manner stated. s stated.
3 £ 8		29b. Signature and ti		0			1	icense i	6 d	00	9	29d. [	pate signe	ed (Month,	Day, Year)
20		30. Name and address	of person w	o completed caus	se of death (Item	23a) (Type,	Print)	Ri	0	Ha	405 X	200	no	W	21742
Stai	e	31. Date filed (Month	Year)	32.1	egistrar's Signa	ture	Lines			(					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24362 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $\mathbf{Ju}^{Month}_{\mathbf{y}}$ 12<sup>ay</sup> 2012 5:40 P M Sr. Hennessey Niland Thomas Facility Name (if not institution give street and number) on and 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Montgomery Nursing Center Sandy Spring If Under 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Min (Month, Day, Year) |579**–**05**–**1999 1 🏻 M 2 🗆 F District of 92 Nov. 2,1919 Columbia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 4977 Battery Lane Apt 608 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ed Forces?
Yes 2 \( \text{No WW II} \) Black, White, etc Armed Forces 1 X Yes 2 [ If Yes, Give Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Christmas Ornaments Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Hennessey Dennis Joseph Niland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4977 Battery Lane Apt 608, Bethesda, MD 20814 Mary Kevin Niland (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 C

permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. Physician/ Medical **Examiner** 

Physician/

Medical

10a. State

MD

Director

Funeral

þ

Completed

Be

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Examiner

**Funeral** 

**Director** 

28a-f show at

items 23a or 28a-f s ner must be notified

Examiner

the Medical

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"natural"

Ith and Mental H 27 is marked of r traumatic ever

hours after death with the Maryland

within 72 al Hygiene.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760

Examine Completed by Physician/Medical plnous Be မ Certificate: rwithin 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu

Medical

25. Was case referred to medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ms M.

2 💢 No

5 Pending

Investigation 6 Could not be

determined

1 6 2012

1 🗌 Yes

27. Manner of Death

1 🔀 Natural

29a, Certifier

Accident Suicide 3 ☐ Suiciae 4 ☐ Homicide

4 Donation 5 Other (S		Gate of	Heaven	2012	10,	Silv	er Sp	ring,	MD
21. Signature of Funeral PRACE THE	M01	117	22. Name and Address of DeVol Funera	Facility 1 Home, Gaithers	10 Eas	t De	er Pa: 0877	rk Dri	ve,
23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if a 13, loading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Aortic S Due to (or as a		t enter the mode of dying, su					Approx Interva	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23	3d. Date of o	delivery Day	Year
Part II. Other significant condition  Congestive Head		t not resulting in	the underlying cause given in	n Part I.		res 2 🔀	(No 3 🗆 24b. Were a	autopsy findi o completior	4 Unknowings available

autopsy performe Yes

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

July 13, 2012

Other: 4 X Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28c. Injury at

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 No

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D23124

29c. License number

State

Registrar

10t

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Hannon M.D., 3300 Olney-Sandy Spring Road Suite 330, Olney MD 20832

ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MO

1 
Inpatient 2

28a. Date of injury (Month, Day, Year)

Numan

2-05483		Please Type or Print in Black Indelible I	ink. Ensure All Cop	ies Are Leg	ible.	
David Christop	her	Neaves State of Maryland / Department of 1-For State Registrar Certificate of Maryland / Department of 1-For State o	f Health and Mental F	_	20	12 243
hysician/ Med Exam		David Christopher Neaves		July 21, 201		3. Time of Death 2139 hrs
		4a. Facility Name (if not institution, give street and number) 12134 Little Patuxent Parkway	4b. City, Town, or Location of Deat Columbia	h	4c. County of Dea Howard	th
Funeral Director		5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) 633-26-0396 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24Hr Months Days Hours Miles	n.	C	irthplace (State or Foreign country)
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca		06/29/1	1991	TX  10d, Inside City Limits
*	or	MD Howard Columb				1 Yes 2 No
the a or	Director	10e. Street and Number  12134 Little Patuxent Pkwy #K	10f. Zip Code 21044		Citizen of What Cou	
8 8 4	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 11. Wes Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	United St. 14. Race - Ame White, etc.	nican Indian, Black,
rs after de aral", or	by	3 Widowed 4 Divorced If Yes, Sive Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Deceder	Yes 2 X No specify:	wade dana Edi	Specify: Wh:	
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene Important: If them 27 is marked other than "natural", or then injury or other traumatic event, the M. Heal Exar and the strains of	oleted	Elementary/Secondary (0-12) College (1-4 or 5+) during r	nost of working life. DO NOT use ret	red)		
21215-0036 buld be filed within 7 Mental Hygiene marked other than ic event, the Milan	Complet	17. Father's Name (First, Middle, Last)	Student 18.Mother's Name	e (First, Middle, Maid	Educat: len Surname)	ion
2121 ould be f d Mental s marked	To Be	David R. Neaves  19a. Informant's Name/Relationship (Type, Pont.)  19b. Mailin		G. Holman Rural Route Number		, Zip Code)
e, MD and 2 sho Health and ttern 27 is traumati		20a. Method of Disposition 20b. Place of Dispos	1 Folly Quarter sition (Name of cemetery.		icott City	
Baltimore, cernit. Pages 1 ar Department of Hes important: If the		1 Burial 2 Cremation 3 X Removal from State crematory or o 4 Donation 5 Other Specify Pinecrest	Mem Park 07/	28/2012	Alexander	. Arkansas
Ball permit Depart Impon injury		4	Name and Address of Facility Har 12 Old Columbia	ry H. Wit	zke's Fan	mily FH Inc.
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Combined drug (De	e mode of dving, such as cardiac or	respiretory arrest is	hock or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ruted nd ransit	_	events resulting in death) Last  ue to (or as a consequence o.).				
50, te be execute ysician and burial - trans	ledica	■ MENDED 23a,27,28a-f,p  IF FEMALE: 23c, If yes, outcome of pregnancy	per me,g930 8-3-1	l2 sm		
Box 68760, e death certificate buthe attending physical for use as the buthe buther for use as the buther for		23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregna	ancy	23d. Date of delivery Month	Day Year
O. Bo): the death by the att	Phys	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the ur		23e. Did tobac	cco use contribute to	the cause of death?
IS, P.( quires tha en signed ald be det	ted by			1 Yes		bably 4 X Unknown
Division of Vital Records, P.O. Box 68760, and or attending Physician: The law requires that the death certificate be execut are after death.  Tal Director: After this certificate has been signed by the attending physician and lled in by the funeral director, page 2 should be detached for use as the bunal - trans	Completed			eutopsy performe	prior to	utopsy findings available completion of cause of
/ital Frician: 1	a .	25. Was case referred to medical examiner?  1 X Yes 2 No   Thospital 1 Inpatient 2 ER/Outpatient	26.Place of Deeth (Check 3 DOA Other; 4 Nursin		sidence 6 X Other	
n of \admin of \admin of \alpha adming Phy h. : After the funeral of \alpha admin of \alpha ad	on: To	27. Manner of Death  1 Natural 5 Death  28a. Date of Injury (Month, Day, Year)  28b. Time of I	njury 28c. Injury at Work?	28d. Describe how		Coone
Divisior pital or Attend ours after death eral Director:	ertification:	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street	UZILA	28f. Location (Stree	et and Number or Rui 3)12134 T.i+	rel Route Number, City <b>tle Patuxen</b>
ours ours	ē	4 Homicide determined (Specify) Residence		Pkwy. Co	lumbia, MI	).

To Homicide (Specify) Residence (Specify) Resi 29d. Date signed (Month, Day, Year) OCME O.C.M.E. July 22, 2012 Theodore M. King, Jr., MD.

State 31. Date filed (Monty) 12, 21, 4 2012 Registrar

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ July Day V. 2012 Year Ngoc 10 7:29 Medical 0729Am 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Funeral (Month, Dav. Year 577-11-6098 Director 1 🖾 M 2 🗆 F 74 Jan. 1, 1938 Vietnam Usual Residence of Decedent 28a-f shov 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Burtonsville Montgomery 10e. Street and Number , or items 23a or 10g. Citizen of What Country? Funeral 20866 3810 Dustin Road USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2012 11. Marital Status 14 Bace - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other transmitters. Completed by 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 Asian 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Soldier Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Dao V. On Lan T. Dang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19108 Stanleybridge Road, Germantown, MD 20876 Tony Tran On/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State July 13, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Respiratory
Due to (d as a consequence of): disease or condition resulting in death) Medical Examiner neumonia Secretarilla list percitions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Dancreatic Cancer burial-transit Meta stasis that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within Z4 hours after death.

To the Funeral Directoral this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be ( 26. Place of Death (Check only one) Other: 4 \( \text{\text{Nursing Home}} \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signatu 29d. Date signed (Month, Day, Year) 10067210 10/1 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) Research Bird, Rockville MO. 20850 31. Date filed State JUL 12 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24365 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13<sup>Day</sup> 2012 Year July Physician/ 2:10 Joseph Pitta Medical 4c. County of Death
Howard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 92 572-09-9548 **Director** Yrs 09/19/1919 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2X No Ellicott City Howard MD 10e. Street and Number 10g. Citizen of What Country? Funeral 21043 4653 Palomino Court United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. White 3 X Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) General Motors Auto Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be fitnern of Health and Mental tant: If item 27 is marked jury or other traumatic events. Laura Pontes Jose Pitta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4653 Palomino Court Ellicott City, MD 21043 Kathleen Reid - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Important: It any injury or 07/13/2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final FAILURE Onset and Death RESPIRATORY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA Secretially list our ditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ☐ Live Birth ∠ ☐ Fregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ISCHEMIC STROKE 2 No 3 Probably 4 Kunknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 K Other (Specify) Hos 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d, Describe how injury occurred Certificate: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director. Af completely filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) title of confifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a July 13th 2012 D72139 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA MD 21044 ABBAS 31. Date filed (Month, Day 32. Redistrar's Signature State 13

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ artha Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** utish: noter Bornesboro

If Under 1 Year If Under 24 Hrs.

Davs Hours Min. Johrney Keedy Home 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Country) 073-05-5862 Director 1 □ M 2 🛛 F 97 Aug. 12, 1914 New York 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland at Director 3a or 28a-f sh be notified a 1 Yes 2 No Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 17956 Garden Lane 21740 USA must ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Yes 2 X No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Nidowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) diocese of other than Elementary/Secondary (0-12) College (1-4 or 5+) secretary Pittsburgh of Health and Mental Hygi item 27 is marked other other traumatic event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martha Catherine Gutmann Arthur J. Caton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Nancy A. Zies - daughter 9816 Woodside Ct., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō Department of Important: If any injury or Hagerstown Crematory | 7/18/2012 Hagerstown, Maryland Signature of Funeral Service I 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ementio Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Physician/Medical Exami Hospital or Attending Physician: The law requires that the death cer ficate be executed as the burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 9 Unknown Division of Wital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed' death? 1 ☐ Yes 2 ☐ No After this certificate Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 24 hours after death. Funeral Director; A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies within 24 hou

To the Fune

completely fi (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 7 who completed cause of death (Item 23a) (Type, Print) tagerstown lan egistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Betty R. Preston 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegan Western MD Regional Medical Center umberland If Under 2 8. Date of Birth (Month, Day, Year) 9. Birthplace State or Foreign Age (In yrs. last birthday) **Funeral** Months Days Hours Country) Director 1 M 2 M F 220-30-8195 80 April 01, 1932 Maryland Yrs ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 X No Mount Savage Maryland Allegany 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 15928 Mount Savage Road, N.W. Funeral 21545-U.S.A Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify If Yes, Give Year or Dates. Specify: "natural" 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewonce. ပ Pauline Bever Norman S. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21545-Kenneth Preston 14447 Mile Lane NW Mount Savage Maryland altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Savage Maryland July 16, 2012 Saint George's Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ tor; After this certificate has been signed by the atter the funeral director, page 2 should be detached for i in the past 12 months? Month Day Year Pregnant at time of death 2. No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 \( \tag{\chi\_10} ျ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director; After of completely filled in by the funer injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21502 924 Seton Drive, Cumberland, Viekramadilya Poonai

State

Registrar

31. Date filed (Month, Day, Year)

3 2012

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2

Certificate of Death

24368

Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Item Items and injury or other traumatic event, the Item Items Items to rottled at 2008.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buildargast

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the the	cat	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	not be					Yes 2 □No					
irec by	Ħ	4 ☐ Homicide	determ		<ul> <li>e. Place of Injurbuilding, etc.</li> </ul>	y - At hor (Specify	ne, farm, str )	eet, factory, office			ocation (Street Dity or Town, Sta		er or Rura	al Route Number,
ral D	Certification:													
To the Funeral Director: After this certificate has been signed by the att completely filled in by the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director.		29a. Certifier (Check only	1 Certifyir	ng Physician	n: To the best o	my knov	ledge, deat	n occurred at the t	me, date and p	place, and	due to the cause	e(s) and ma	inner as s	stated.
he Fi	Medical	one)	wedical	Examiner:	on the basis of and manner stat	ed.	on and/or in	vestigation, in my	ppinion, death (	occurred at	ine time, date a	and place, a	and due to	o the cause(s)
Totl	Ž	29b. Signature and	title of certifie	A				29c, Licen	se number		29d. I	Date signed	d (Month,	Day, Year)
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		30. Name and addre			/					<u>.</u> -	4 -	00000		
- 01		Alan R. 31. Date filed (Mont		M.D.	1517 F 32. Registra	ugo	Circle	e, Silver	Spring	g, Ma	ryland :	20906		
Sta Registra	_			2012	a Line Gista	J Jigilali	A. 1	arke).						
negisiii	-1			2012	Lenn	~ /	- 7	, *						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Allen R. Price 7:30 PM Medical 2017 Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death a NICOMICO Sex 1 XM 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign MD **Funeral** Months Hour 2-13-1936 **Director** 217-30-9816 76 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Wicomico MD Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8410 Riggin Road 21837 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc 2 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Yes Give Specif Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maintenance Deer's Head Hosp Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Oscar Price Maggie H. Gattis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau Florence Price/Wife 8410 Riggin Road, Mardela Springs, MD 21837 20a. Method of Disposition 20b. Place of Disposition (Name of Cem cemetery, crematory or other place) 20c. Location - City or Town, State Date ¹X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) James Free Meth7-15-2012 Quantico, MD 21. Signature of Funeral Service Licenses McPherson Funeral PO Box 326 Service Milford, DE 19963 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ mallanant disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to jor as a consequence on that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day 2 No 9 Unknown 9 Unknown P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 1 ☐ Yes 2 ☑ No Yes 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No HOSDICE. မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending work s after death. 1 Yes 2 🗌 No \_\_ Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Box 1733 Salisbury MD 21802 30. Name and address of person who completed cause of death (Item 23a) (Type Grint)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

13 2012

12-05070 Vera Janet Price Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 24370 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month D July 6, 2012 **Medical Examiner** 1155 hrs Vera Janet Price 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Naylor Mill road and Salisbury bypass/Route 13 Salisbury Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 218-48-8724 1 M 2 X F 12/19/1947 Country 64 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 X No Maryland Prince Georges Landover with the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 7212 Hawthorne St. 20785 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after of Health and Mental Hygiene. 4 Divorced If Yes, Give Year or Dates: 3 Widowed 1 Yes 2 X No specify: Specify: Black à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Specialist National Security 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be John Moore Corinda Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print) Wayne S. Price/Spouse tof Health a. it: If item 2' 7212 Hawthorne St., Landover, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Friendship U.M.Church 7/14/2012 Wetipquin, MD Donation 5 Other Spec Cemetery

22. Name and Address of Facility
Stewart Funeral 21. Signature of Funeral Service Licensee Home by Holloway and Downey,P.A alisbury, MD 21801 West Rd., 23a. Part I. Enter the disease, or complication s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical physician a UNPENDED AMENDED The law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the use as t Fetal death 3 Ectopic pregnancy Year Day past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 V No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attendiog Physiciao: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other Scene this 1 V Yes 28a. Date of Injury (Month, Day,Year) Jul 6, 2012 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject driver in auto auto collision 1 Natural 1155 hrs 1 Yes 2 ✔ No death. Pending filled in by the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Naylor Mill Road & Rt. 13, Salisbury, MD determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. July 7, 2012 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed ( State 2. Registrar's Sign

DHMH 17 Rev 1/2001

Registrar

OCME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Walter Henry Polk 1935P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CENTA 546156414 RECIONAL Medical TENINSULA MICOMICO Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. (Month, Day, Year) Director 216-74-4955 1 X M 2 □ F 52 8-25-1959 MD 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10b Count 10c. City, Town or Location Director 10d. Inside City Limits MD Wicomico Fruitland 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21826 127 Moonglow Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. ☐ Yes 2 🔯 No Maryland 21215-0036 1 Yes 2 XNo Specify If Yes, Give 3 Divorced Specify Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Flagger American Paving Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ John E. Polk Marybelle Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health attem 27 Mary Wilson/Sister 127 Moonglow Road, Fruitland, MD 21826 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of h Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Departion 5 Other (Specify) .Mary's Miss Cem 7-15-2012 Princess Anne, 21. Signature of Funeral Service Licensee 22 Name and Address of Facility 917 W. Bennie Smith Funeral Home Salisbu Isabella St. Home Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CORONARY ARTERY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SUBENDOCARDIAL MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam CORONARY ARTERY BYPASS SURCERY that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical HYPOXIC ENCEPHALOPATH use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box ( 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) signed by the atter in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, icate has been sig r, page 2 should b CHRONIC OBSTRUCTIVE PULMONARY 1 Yes 2 No 3 Probably 4 Unknown LEFT VENTRICULAR 24b. Were autopsy findings available prior to completion of cause of death? DYSFUNCTION 24a. Was an this certificate has autopsy CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completely filled in by the funeral director, Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕱 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After th Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation 6 Could not be ☐ Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certified 30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

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Registrar's Sign

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FOF	partment of Health and Mertificate of Death	lental Hygien Reg. No	7111/ /4316						
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death						
	Physicia /Medic		Javielle Nicole Phillips		July 3, 2	012 Year 1540 PM						
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	c. County of Death						
-			Holy Cross Hospital	Silver Sprin	.g	Montgomery						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	/) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year,	9. Birthplace (State or Foreign Country)						
и	Director		218-27-1793 26		Jan. 5, 19							
	put M		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or I	ocation		10d. Inside City Limits						
	aryla sho	5			_	1 ⊠Yes 2 □ No						
	he M 28a-f otifie	ect	Maryland Montgomery  10e. Street and Number	Silver	Spring	itizen of What Country?						
	a or	늅		·		,						
	s 23	eral	2112 Harlequin Terrace  11 Marital Status 12, Was Decedent Ever in U.S. 13	Was Decedent at Historia Origin? (Sp		Jnited States  14. Race - American Indian.						
	er de item ner r	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑Never Married 2 ☐ Married  13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Armed Forces? 1 ☐Yes 2 ☑No.	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.						
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212	with giene r tha	E	Elementary/Secondary (0-12) College (1-4or 5+)	Sales Clerk		Private						
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Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show raumatic event, the Me 2cm Examiner must be notified at	으	Jerry Lee Phillips	Shirl	ey Denise	Todd						
ary	shot and A s mai		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, A									
_	s 1 and 2 should of Health and Mer item 27 is marke other traumatic	13	Shirley Denise Todd - Mother 2112	. Harlequin Terrace	Silver S	pring, Maryland						
altimore,	item		20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place)  July	Date 20c. L	ocation - City or Town, State						
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ä	permi Depar Impor any Ir		John T. Slenbert MO0560	4001 Benning Road N	NE Washing	ton, DC 20019						
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between						
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	/Medical		disease or condition resulting in death)  a. End Stape Rena Due to (or as a consequence of):	I Disease								
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		Med	IF FEMALE:									
Box	Physician: The law requires that the death certific this certificate has been signed by the attending Fraid director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	□ Ectopic pregnancy	ľ	23d. Date of delivery						
O.E	ie dea the at hed fo	sici	1 Yes 2 No 4 Pregnant at time of death	Other (specify)		Month Day Year						
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ita	sician: The certificate rector, pag	Be (	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)							
of Vital Records,	Physici this cer al direc	To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 □ DOA Other: 4 □ Nursing Ho	me 5 Residence	6 ☐ Other (Specify)						
n o	ding Ph h. After th funeral	ü	27. Manner of Death 1 XNatural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time Injury		28d. Describe how inju	ury occurred						
Division	ttendi death. ctor: A / the fu	Certification:	2 Accident investigation	M 1 ☐ Yes 2 ☐ No								
Ξ̈́	r Att	ŧ	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, State	and Number or Rural Route Number, te)						
Ω	ital c Irs af ral D											
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, de  2 ★ Medical Examiner: On the basis of examination and/or  and manner stated	atn occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause( red at the time, date ar	(s) and manner as stated. nd place, and due to the cause(s)						
	To the within 2 To the comple	Med	, and mainor stated.	200 Licence number	20d D	ata signad (Manth Play Year)						
_	2 × 6 0	-	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)						
	ia		, , , , , , , , , , , , , , , , , , , ,	D45471	J	July 6, 2012						
	64		30. Name and address of person who completed cause of death (Item 23a) (Typ		254 000	110						
			Yeheyis Negussie 1500 Forest Gle	n Road Silver Spri	ng, Md. 209	910						
	Sta Registr		UL 1 0 2012 Character S. Hegistra's Signature									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CORGIA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Co. Linthicum <u>Tate Hospice</u> House If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 M 2 SXF 92 05-15-1920 So Carolina Director 246-34-2366 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Temple Hills Yes 2 No PG MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ıral", or items 23a oı Examiner must be Funeral 20748 4400 Ranger Avenue within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ▼ No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Black "natural". 3 Widowed 4 Divorced Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+)
2 vrs Elementary/Seconday (0-12) Child Care Day Care Director yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental H 27 is marked of traumatic ever Hattie Harrison George Edward Harling 190 Mailing Address (Street and Number or Rucal Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) and 2 st Health a tem 27 is Elaine Gales (Daughter) Temple Hills, Maryland Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 2 Department of 1 ☐ Burial 2 ☐ Cremation 3 😾 Removal from State 7-21-2012 Asheville, N. Carolina Riverside Cem. 4 Donation 5 Other (Specify) Signature of Funeral Service License Ralph Williams, II Funeral Service, 5202 PrincetonsDelightDr., Bowie, MD P.A. 20720 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer see and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conseque nce of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical certificate be be detached for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Year Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of performed Yes 2 page death? 2 🗌 No 1 Yes ☐ Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending Natural N 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours aff To the Funeral Di Medical t ← Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 0 completed cause of death (Item 23a) (Type, Print) Am NICHAEL 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

of Vital Records,

Division

			AMEND #25,27	lease Type or P ,28A-F, PER I State of	rint in Bla	ack Inde 8/8/12	lible Inl	k. Ensure	All Copie	s Are	Legible		
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10	Medi Examir		4a. Facility Name (if not institu	Reed ution, give street and number	)	4b.	City, Toyvn, o	r Location of Dea	101Y	40	County of Dea	13:15 am	
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7	land show d at	ğ	Usual Residence of Deceder 10a. State 10b. Con		10c. City, To	wn or Location		1	0,20,2			10d. Inside City Limits	
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	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	79 Garner	Avenue			0602			_	tizen of What Co ted Sta	•	
a s	r death v or items niner mu		11. Marital Status  1 Never Married 2	12. Was Deceden Armed Forces Married 1 Tyes 2	t Ever in U.S.	If Yes,	specify Cuba	n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		14. Race - Ame Black, Whit		
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35	d withir tygiene ther tha nt, the	Be Co	Elementary/Secondary (0-		5+)	Home M	aker			1	n home		
/ (	should be filed within 72 hours afti and Mental Hygiene. is marked other than "natural", aumatic event, the Medical Exar	10 E	17. Father's Name (First, Midd Paul Du	tko				18. Mother's Na Helen	ame (First, Middle, <b>Zagata</b>		Surname)		
Mary	permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once.		19a. Informant's Name/Relati		- 1				ural Route Numbe			o Code)	
	of Health		Mark Ree 20a. Method of Disposition		20h Place	79 Garn of Disposition	(Nome of		orf, MD.		02 ocation - City or	Town, State	
$\mathcal{P}_{\mathcal{U}}$ altimore,	Page tment c tant; If tury or		4 Donation 5 Oth		Resur			ery 7/	17/2012	Cli	nton, M	D.	
Bal	permit Depar Impor any in once.		21. Signatule of Funeral Serv	ce Licensee		150			untt Fun			D 00601	
	TWY.		23a. Part 1. Enter the disease shock, or heart failure. L	e, or complications that caus ist only one cause on each li	ed the death. Do				ton Road c or respiratory ar		gort, e	Approximate Interval Between	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Oli	ered	Men	tal	State	<b>1</b> 20.			Onset and Death	
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	executed ian and urial-transit		that initiated events resulting in death) Last	c. Due to (or as	s a consequence	of):	<del></del>	TION APP	ONER BY WERK	LEXAMIN	VER .		
68760	cate be physic s the b	ledica		d			C	ERTIFICATION					
× 68	eath certificate be attending physici I for use as the bu	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live Birth	e of pregnancy 2  Fetal dea	th 3 🗆 Ector	oic pregnanc	y		Į.	23d. Date of de	ivery	
Box.	that the deat ned by the at detached fo	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown		at time of death						Month	Day Year	
P.O.	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physicitiely filled in by the funeral director, page 2 should be detached for use as the by		Part II Other significant con		^	-1						the cause of death?	
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$\neq$ $33\beta$ Division of Vital Records,	Physician: The law r r this certificate has baral director, page 2 s	Be	25. Was case referred to medi examiner? 1 X Yes 2 W No	Hospital:			Otho	ace of Death (Che	ck only one)				
of V	ng Phy: ter this ineral d	ite: To	27. Manner of Death	28a. Date of inj		utpatient 3 L Time of Injury	28c. Injury works	4 □ Nursing F at	dome 5 Resid			ífy)	
Sion	Attendii death. ctor: A: yy the fu	Certificate:	2 X Accident Inv	estigation uld not be		M M	1 🗆 '	Yes 2 No	PROBABL			al Route Number,	
Divi	ital or / irs after al Dire			FOUND:	tc. (Specify) <b>HOME</b>				WALDORF	n, State) MD	FD: 79	GARNER AVE	
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Medical	(Cheyck / 2,L_I Medic	ving Physician: To the best of al Examiner: On the basis of incolurse Practitioner: To t	examination and/	or investigation	in my opinior	<ul> <li>n. death occurred</li> </ul>	at the time, date a	nd place.	and due to the o	ause(s) and manner stated	
	To the To the comp	2	29b. Signature and the of office	Mh	ne best of my kind		29c. License				e signed (Month		
			30. Name and address of pers	on who completed cause of	death (Item 22a)	(Type Print)	D4	16419	,	Ju	ly 13,	1012	
,	00-5		Charleno 1	otchtord	MD	(Type Plint)	Gar	rett A	ve Lo	iPl	lata, 1	10 20646	
	Stat Registra	e ir	31. Date filed (Month, Day, Yea	8 2012 32. Fegist	rar's Signature	back	1				,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\mathbf{July}^{\mathsf{Month}}$ Day Constance Louise Remler 2012 11 Medical 12:00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Davs (Month, Day, Year) 579-34-6487 Director 1 M 2 X F 86 March 8, 1926 Usual Residence of Dec NY 28a-f show 10a. State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits notified MD Montgomery 1 Yes 2X No Silver Spring the 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 901 Arcola Avenue 20902 USA items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Examiner Armed Force 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🔣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify "natural", 3 Widowed 4 Divorced Specify: White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Salesperson Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Wittenauer Constance Munns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Davis/Guardian 2nd Floor, Rockville, Hungerford Drive. MD 20850 20b. Place of Disposition (Name of cemetery crematory or other place)
Gate of Heaven 20a. Method of Disposition Date 16, 20c. Location - City or Town, State July 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Cemetery 2012 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Acute Respiratory Failure Medical Due to (or as a consequence of) **Examiner** Bilateral Pneumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 2 X No the a 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has perform 1 Yes 2 No Yes 2X No ours after death.

eral Director: After this certific; filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗆 Xio Other: 잍 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours a Medical ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Vegusse D45471 July 11, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registra

Yeheyis Negussie, MD

1 6 201

31. Date filed (Month, Day, Year)

1111 Spring Street, #214, Silver Spring, MD 20910

12-05107 Henry L. Reid

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 24376

		1- For State Certificate of Death Reg. No.								
Physici		1. Decedent's Name (First, Middle,Last)  2. Date of Death  3. Time of Death								
Medical Exam	iner	Henry Louis Reid July 7, 2012 1440 hrs								
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Laurel 4c. County of Death Prince George's								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Months   Days   Hours   Min.								
Director		239-60-5639   1x M 2 F   72   Yrs.   Months   Days   Hours   Min.   Aug. 31, 1939   No Carolina   Usual Residence of Decedent								
any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits								
	_	MD Prince George's Laurel								
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?								
th the Maryland 23a or 28a-f sho notified at once.		8896 Cherry Lane 20708 USA								
th with	Funeral	11. Marital Status 1								
5-0036 led within 72 hours after death with the Maryland tygiene other than "matural", or items 23a or 28a-f she the Medical Examiner must be notified at once		1 Yes 2 X No specify:  Black Specify:								
ours a atura xamin	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)								
15-003 iled withii Hygiene. d other th	mo	12 Transportation County Government  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)								
	Be C	Hazel P. Reid Mable Fox Reid								
	To	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
ore, MD ss I and 2 sho of Health and If item 27 is		Denise Reid - Daughter 627 - 71st. Ave., Capitol Heights, MD 20763  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State								
Baltimore, permit. Pages I ar Department of Hes Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place)								
Baltimo permit. Page Department o Important: injury or oth		Gate of Heaven Cem. 7/13/12 Silver Spring, MD  21. Signature of Funeral Service Licensee A 22. Name and Address of Facility								
Ba Perm Depa Impo injur		June Funeral Service Inc. 120012								
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and								
/Medical Examiner		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease Death								
	!	or condition resulting in death)  Due to (or as a consequence of):								
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause, Enter Underlying Cause								
T DE	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
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760, icate be e g physicia the buria	/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery								
,- 00	an/N	3b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year								
Box 687, he death certifi	Physician	4 Pregnant at time of 5 Other (Specify)  1 Yes 2 No 9 Unknown g Unknown								
O. B r the da by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?								
Records, P.O. The law requires that the crate has been signed by page 2 should be detach	b	Chronic Alcohol Abuse								
rds, requir been s	letec	24a. Was an 24b. Were autopsy findings available								
Records,  The law require ficate has been si page 2 should b	Completed	autopsy performed?  performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No								
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of Vital ng Physician: After this certi nneral directoi	o B	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing Home 5 Residence 6 ✓ Other: Scene								
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Division ral or Attendi rs after death.  al Director: / led in by the fi	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
ospita hours neral y fille		4 Homicide (Specify)								
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  One)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	Mec	and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)								
7		O.C.M.E. July 8, 2012								
	}	30. Name and addgess of person who completed cause of death (Item 23a)								
		Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
Si Regis		31. Date filed (Month, Day, Year) 37. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 231 A M Rollev Bunklev 0 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner the La PICE comico 6. Sex If Under 1 Year | If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Country) Director 457-05-6203 1 □ M 2 🕅 F Texas 1-29-1920 92 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If them 27 is marked other then "netural", or items 23a or 28a-1 shown injury or other treumatic event, the Marker Examiner must be notified at eny injury or other treumatic event, the Marker Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1109 S. Schumaker Drive #326 21804 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carpenter Mae Bunk1ey Myrtie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 196, Matlacha, Florida 33993 Donna Black - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 7-16-2012 Delmar, Delaware 21. Signature of Funeral Service Licens Bounds Funeral Home 22. Name and Address of Facility 705 E. Main Street, Salisbury, Maryland 21804 23a. Par 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of fining) Examine Due to (or as a consequence of) burlal-transit Cause (Disease of Trijury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 use as the IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown ò Month the detached 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ cate has been siç ; page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of or Attending Physicien: The law autopsy performed? Yes 2 1 To the Hospital or Attending Proyscient the within 24 hours after death.

To the Funerel Director: After this certificate? completely filled in by the funeral director, pag 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 1 ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Registrar's Signat State Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRANCES ROBINSON Month Day ANNA Р THEY 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner HAGERSTOWN WASHINGTON 12463 GATEWAY AVENUE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🗓 🗶 11/3/1939 WEST VIRGINIA 72 Director 234-60-3187 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Director must be notified WASHINGTON HAGERSTOWN 1 Yes 2 No 28a-f MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 21740 12463 GATEWAY AVENUE USA "natural", or items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE Specify: 3 X Widowed 4 ☐ Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 18b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PRIVATE Elementary/Seconday (0-12) College (1-4 or 5+) CAREGIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FRANCES LEE MURPHY ELMER THOMAS EMMONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICKY D. ROBINSON/SON 12463 GATEWAY AVENUE, HAGERSTOWN, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Department of H Important: If ite any injury or ot 7/10/2012 MARTINSBURG, WV SMOKETOWN CEMETERY Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, MARTINSBURG, WV 25402 327 W. KING ST., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) outmon. con Medical Due to (or as a onsequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Aumund Examine ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a conseque resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Other (specify) Pregnant at time of death 5 2 No 9 Unknown Linknown thin 24 hours after death.

the Funeral Director: After this certificate has been signed by templeted filled in by the funeral director, page 2 should be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2. No Hospital မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1- Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completed filled Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 32518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leedysville MD Wyand

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death  $J_{uly}^{Month}$ <sup>Day</sup> 2012 Physician/ 11 7:12am Betty Jo Slaback Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 122 East DeerPark Drive Gaithersburg Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country. Director 525-82-6772 1 □ M 2 🛛 F 71 Dec. 1, 1940 Mississippi Usual Residence of Decedent ms 23a or 28a-f show must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20877 122 East Deer Park Drive United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 X Married Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lloyd Boyd Lillie Rowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester Slaback (Spouse) East Deer Park Drive, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 7/11/12 Alexandria, Virginia Signature of Funeral Service L 22. Name and Address of Facility DeVol Funeral Home Gaithers Barg, Park Drive 28a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or beart failure. List only one cause or Immediate Cause (Final Onset and Death Physician/ Fallure to Thrive Syndrome, Adult Medical resulting in death) Examiner Chronic Osteomyelitis of Femur 1 Year Sequentially list conditions. Examine il any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Decubitus Ulcers 1 Year Due to (or as a consequence of) Physician/Medical Hypertensive Chronic Kidney Disease 1 Year Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months?

1 Yes 2 X No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 1 ☐ Yes 2X No Yes 2 X No filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 🔀 No Certificate; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) D0066963 11,2012

Registrar

DHMH 17 Rev 06-2011

State

Registrar's Signature

655 Watkins Mill Road, Gaithersburg, MD 20879

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mina Son, M.D.

31. Date filed (Month, Day, Year,

JUL 12 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ SANCHEZ FRMD 1464 2012 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death County of Death
Montgomery **Examiner** Sanctuary at Holy Cross Burtonsville Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min 3/1/9/1/9/59 none 1**X**□ M 2 □ F 53 Bolivia Director iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring MD 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20902 Bolivia Funeral items 23a 12236 Bond Street 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, or i Yes 2 X No Yes, Give b 1 Never Married 2 Married 1♥ Yes 2□No Specify: Bolivian Maryland 21215-0036 within 72 hours after White permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exar Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Maria Victoria Guillen unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12236 Bond Street Silver Spring, Md 20902 19a. Informant's Name/Relationship (Type, Pri@Ompanion Ana Lilian Barrientos/ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1  $\square$  Burial 2  $\blacksquare$  Cremation 3  $\square$  Removal from State chesapeake Crem Beltsville, Md 7/14/2012 4 Donation 5 Other (Specify) PATLITPOODS KTWALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each LMONARU BROSIS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to lor as a consequence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year signed by the at Id be detached for 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **p** MALNUTRITION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of 24 hours after death.
25 Hours after death.
46 Huneral Director. After this certificate has letely filled in by the funeral director, page 2 autopsy performed death? 1 🗌 Yes a No Yes 2 No 25. Was case referred to medica Be 26. Place of Death Check only one examiner? 2 No Other 1 Inpatient 2 I ER/Outpatient 3 I DOA မ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending 1 Yes Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hou

To the Funer

completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one 29b. Signature/and title of certifier 29d. Date signed (Month, Day, Year) 28595 nu Bliebei 30. Name and address of person who completed cause of death (Item 23a) (Type, Print MI) BOX 1525 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Milton Stafford Pau1 June 2012 9:49 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberland Allegany Allegany Health Nursing and Rehab Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Hours 1 🕅 M 2 🗆 F 75 11/17/1936 Maryland 216-38-5047 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director MD Allegany Cumberland 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 631 Lincoln Street within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 2 □ No 1956-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 🗌 Widowed 4 🗌 Divorced 1960 Completed White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Housekeeping Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stafford May Blubaugh Charles Bessie Hanson Should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 631 Lincoln Street, Cumberland, MD Kathleen Stafford / Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Vet Cem @ Rocky Gap 07/02/2012 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si nature of Funeral Second 22. Name and Address of Facility Adams Family Funeral Ilome, 404 Decatur Street, Cumberland, MD 21502 Loter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Masse Pnysician disease or condition resulting in death) 10 Medical Due to (or as a consequen > of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Yes 2 No is certificate has been signed by the director, page 2 should be detached 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 XNo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Perfitying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 20/2 33282 S

State Registrar 625 Kent Avenue, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sunil K. Gupta, M.D.,

31. Date filed (Month Page 1912)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 13<sup>pay</sup> LOTS OBLENDER STONER 20 ľ2 8:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 2405 McCormick Road Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 203-24-6426 Director 1 □ M 2 🔀 F 82 June 28,1930 Pennsylvania 28a-f show aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Montgomery Rockville 1 Yes 2 X No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 2405 McCormick Road 20850 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. "natural", or Yes 2 XNo Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Montgomery County and 2 should be filed within 72 Health and Mental Hygiene. Legislative Analyst Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard Oblender Marguerite Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2891 Balmoral Dr. Rockville, MD 20850 item 27 Richard O. Stoner (Son) injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of July 16, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite
any injury or ott cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parklawn Mem. Park Rockville, MD 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licent 22. Name and Address of FacilityDeVol Funeral Home (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Provolcian/ years Metastatic Rectal Cancer disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine frany, leading to mineulate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending ph I for use as th IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 X No Pregnant at time of death 1 Yes 2 2 9 Unknown g Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅙ 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? has s certificate has lirector, page 2 perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗓 No Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer (Month, Day, Year) 1 X Natural 5 Pending М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and attended certific 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of pers

31. Date filed (Month, Day, Year

Dr. Paul M. Thambi M.D.

JUL 16 2012

n who completed cause of death (Item 23a) (Type, Print)

D0061083

9707 Medical Center Drive Suite #300 Rockville,MD

July 13, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joyce Sterling 6:01  $p_{\mathsf{M}}$ July 13, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3388 Curtis Dr. #101 Temple Hills 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 577-62-3167 Davs Hours Director 1 🗆 M 2 🔀 F 66. 06-06-1946 Wash. DC Usual Residence of Decedent 28a-f shov 10a. State 10b County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD PG Temple Hills Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3388 Curtis Dr. #101 20746 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Examiner ò 2 XIO þ 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
United States Postal (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Stephen Goodwin Rena McCard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynetta Toliver/Daughter 3388 Curtis Dr. #101 Temple Hills, MD 20746 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or injury or 07-19-2012 Suitland, MD Lincoln Memorial Cem 4 Donation 5 Other (Specify) natur of Funeral Service Lic 22. Name and Address of Facility Ronald Taylor II FH rond 10583 Middleport In. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death evere disease or condition month Medical resulting in death) **Examiner** eass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): iding physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ atten for u in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day Year Pregnant at time of death the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an page 2 autopsy prior to completion of cause of death? 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 12 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier MO P68799 who completed cause of death (Item 23a) (Type, Print) Orchard Drive Silver 220

Registrar

State

31. Date filed (Month, Day, Year)

16 2012

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #21, PER MD G929 7/31/12 TRT
State of Maryland / Department of Health and Mental Hygiene for State Registra 24384 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician/ Loretta May Stransky 8:50 a M 09 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington 124 High Street Sharpsburg Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 232-50-0633 Director 1 □ M 2**X** F 77 West Virginia 09/06/1934 Usual Residence of Deced fshow 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland | Washington Sharpsburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 124 High Street 21782 U.S.A Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2X Married Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes, Give 27 is marked other than "natural", traumatic event, the Medical Exa White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jesse E. Stewart Audrey Tarr and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Robert Stransky / Husband 124 High Street Sharpsburg Maryland 21782 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/12/2012 Hagerstown, Maryland Rest Haven Cemetery 21. Signature ineral Service Lic 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conse Examiner Sequentially list conditions Examine rany, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ months? in the past 12 r 1 Yes 2 9 Unknown Pregnant at time of death Month Day Year detached signed by 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Funeral Director: After this certificate has perform the Hospital or Attending Physician: The 1 Yes 2 No Yes 2 No filled in by the funeral director, ace of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🗆 DOA 5 Residence 6 Other (Specify) 4 Nursing Home 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury after death. Accident Suicide M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined hours Medical 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Newse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Within 2 only one 29b. Signature and tit 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) ess of person who completed cause of State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2012 24385

Angela Marie Schultz 1-For State Registrar  Certificate of Death Reg. No.												12 243				
Physician/ Medical Examiner	1. [				Shı	ıltz						Date of Deeth Month uly 1, 201		Year	3. Time of Death 1821 hrs	
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Funeral Director	5. 8	Social Security Nu		6. Sex		(In yrs, las		Month:	r 1 Year Days	If Under 24 Hours	Hrs. 8 Min.			YYYY) 9. Bii Co	thplace (State or Foreign ountry)	
		229-90-209 ual Residence of D	ecedent	1 M 2 X			41 Yrs			<u> </u>		06/22	2/1971		Virginia	
d any		a. State 1	0b. County P⊶	Georges C		10c. City, T	own or Locati		ville			10d. Inside City Limits  1 Yes 2 No				
the Maryland a or 28s-f sh tited at on	106	e. Street and Numb	per				119	10f. Zip	Code			10	ntry?			
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, it a Town to the remote and the state of the Completed by Funeral Director		Never Married Widowed		arried Armi		No K	If Y	'es, speci	y Cuban, I	Mexican, Pu	erto Ric	an, etc.)		White, etc.	hite	
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Baltimore, sernit. Pages 1 ar Department of He Umportent: If the mjury or other tr	4 21.	Donation 5					Columb 22. N	oia Ga lame and	rdens Address of	Facility <b>M</b> T	$\frac{07/07}{000}$	/2012 Funeral	Home	Arlin	gton, VA	
	634	a Part Frier the	disease or	complications th		0455			4510	) Wilso	n Bl	vd., Ar	lineto	n. VA 2	2203 Approximate Interval	
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ted Insit		any, leading to immuse. Enter Underly iseese or injury that	ediate ying Cause	Due to (or c.	as a conse	quence of):										
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Division of Vital Records, P.O. Box 68760, To the Hoptal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - treas Medical Certification: To Be Completed by Physician/Medical E	29a (Ch one	noon only		nysician: To the miner: On the ba and mann	sis of exam						nd due t	o the ceuse(s	) and man	ner es stated		
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	30.	Name and addres												uly 2,	2012	
State	31.	Ana Rub		.D., 900	O W. P			reet	Ba1t	timore	,Ma	ryland	2122	23		
Registrar	•															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12 AACO HEALTH DEPT OM Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jumph 6. 2012 Shirley Anne Simmons 5:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 109 Archwood Avenue Anne Arundel Annapolis 220-28-8038 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Min. (Month, Day, Year) 1 □ M 2 🗗 F Director Yrs Maryland 8/5/1934 Usual Residence of Decedent r then "natural", or items 23a or 28e-f shov the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Anne Arundel 1 Yes 2 No Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 109 Archwood Avenue 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Eldercare other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of ٥ Anna Caroline Carter George T. Bachmann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 1309 East Central Avenue, Edgewater, MD 21037 19a. Informant's Name/Relationship (Type, Print) 1 and 2 sl of Health a item 27 is Dawn Gilliam - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Mem Gardens 7/12/12 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD John M. Signature of Funeral Service Licenses 22. Name and Address of Facility Taylor Funeral Home 147 Duke of Gloucetser St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician minutes disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Doe to for as a conseque To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death
9 Unknown Dav 5 Other (specify) 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 N 1 Yes 2 🗌 No **Division of Vital** æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nycse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

509

gistrar's Signature

haconas

31. Date filed (Month, Day, Year) 2012

State of Maryland / Department of Health and Mental Hygiene 2 24387 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day July 10, 2012 0956 hrs Betty Jean Simms 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 1800 Palmer Road #422 Fort Washington Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Hours 173-36-5371 Country) 1 M 2 X F Yrs 65 PA 8. Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1800 Palmer Road, #422 20744 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 U S Government Legal Secretary 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Bonnie Sims Laura hutcherson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe B. Simms - brother 10030 Edgewater Terrace, Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department of Important: 1 injury or oth 7/13/2012 Beltsville, MD Chesapeake crematory Inc. Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. K. Johnson Funeral Home, HYNNSU MO1385 Ave., Temple Hills, MD 20748 6503 Old Branch Part I. Enter the disease, of complication failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical a. Pulmonary Thromboembolism Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Bilateral deep vein thrombosis Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - transit Division of Vital Records, P.O. Box 68760, tol or Attending Physician: The law requires that the death certificate be executed /sician/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Fetal death Live birth 3 Ectopic pregnancy use as 1 Day Year Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 Unknown Unknown 퉌 signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 至 1 ✓ Yes 2 No 3 Probably 4 Unknown Multiple sclerosis, hypertensive atherosclerotic cardiovascular disease, diabetes Completed After this certificate has been page 2 should 24a. Was an 24b. Were autopsy findings available mellitus autopsy prior to completion of cause of death? performed' Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 11, 2012 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001 OCME 2006

			for State Registrar	State of Marylar	-	arument of F tificate of L		Mental Hy	giene Reg. No.		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last,					2. Date of De	ath	3. Time of Death	
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	)			Medical Cen	fer		ACISTALLY	,	Nico.		
	Funeral Director		5. Social Security Number 6. Sex 215–20–2054 1 Dusual Residence of Decedent	7. Age (In yrs. )	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th 9. 1927 Ma	Birthplace (State or Foreign Country) aryland	
	aryland a-f shov fied at	Director	10a. State 10b. County  Maryland Wicomic		ty, Town or Loc	cation Salisbury				10d. Inside City Limits 1    Yes 2   No	
	a or 28 be noti		10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?		
	nth with ms 23 must	Funeral	604 Calloway Stree		o lao v		21804		U.S.A		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Š	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates.	"	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🙀 No	in, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify: W.		
215-(	n 72 hore. 9. <b>medics</b>	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed) College (1-4 or 5+)	[ (Give I	lent's Usual Occupa kind of work done of O NOT use retired)		rking	16b. Kind of Busine	ss/Industry	
121	d withii tygiene ther th nt, the	Be Co	12	College (1-4 or 5+)	Licen	sed Praci			Medical		
lanc	d be file dental H irked o tic eve	ם	17. Father's Name (First, Middle, Last)  Vaughn Sterling					me (First, Middle, Landon	Maiden Surname)		
Mary	should n and Me 7 is mar raumati		19a. Informant's Name/Relationship (Typ		1		and Number or Ru	ıral Route Numbe	r, City or Town, State,	Zip Code)	
re, l	1 and 2 f Health item 27 other t		Carla Carter (Daug 20a. Method of Disposition	20b. F	Place of Dispos	7 River I		- Berli	n, MD 218 20c. Location - City		
timo	Page tment o tant: If tant: If jury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crem	natory or other placed. Cemeter	e) y 07/	11/2012	Crisfie		
Ball	permit. Departn Imports any inju	10	21. Signatu uneral Service Licen Robert H. Brads	shaw, Jr.	22. Br 30	Name and Address adshaw & 6 W. Mair	s of Facility Sons Fu	neral Ho	me MD 21817		
- 2	da - vivo - la		23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final	cations that caused the deat cause on each line.						Approximate Interval Between	
~ ·	Pnysician/ Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):					Onset and Death	
	Examiner	e	Sequentially list conditions, if any, leading to immediate	Sepsis							
Т	uted Id ransit	Examiner	cause (Disease or injury that initiated events	Due to (or 🕏 a consequ	uerice oij.						
_	icate be executed physician and is the burial-transit	al Ey	resulting in death) Last	Due to (or as a consequ	uence of):						
3760	ificate l ig phys as the	Medical	F FFW F	1.	*						
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	aldeath 3 🗌	Ectopic pregnance Other (specify)	у		23d. Date of Month	delivery Day Year	
P.0	s that tigned b	by P	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
ords	require been si should	leted						1 🗆 `		Probably 4 Unknown	
Rec	nysician: The law nis certificate has t I director, page 2 s	Som of						autop	rmed? prior t	autopsy findings available o completion of cause of ? //es 2 🏻 No	
<u>ita</u>	ician: certific rector,	å	25. Was case referred to mencal examiner?	ospital:	-	26. Pla	ce of Death (Che	_	Z IDNO	63 2 1110	
<u>ح</u>	g Phys er this neral di	te: To	27. Manner of Death	1 ☑ Inpatient 2 ☐ 28a. Date of injury	28b. Time of	28c. Injury	4 □ Nursing F at		ence 6 Other (Spo	ecify)	
sion	ttendin death. :tor: Afi / the fu	Certificate:	1  Natural 5  Pending 2  Accident Investigation 3  Suicide 6  Could not be	(Month, Day, Year)	injury		? Yes 2 ☐ No				
Division of Vital Records,	ital or A urs after ral Direc		4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	)			City or Tow		5	
	he Hosp in 24 ho he Fune ipletely f	Medical	(Uneck 2 L. Medical Examine	cian: To the best of my knowler: On the basis of examination Practitioner: To the best of n	n and/or investi	gation, in my opinior	n death occurred	at the time date a	nd place and due to the	a cause(s) and manner stated	
	With Con		29b. Signature and title of certifier	wow		29c. License			29d. Date signed (Mo		
	CAL		30. Name and address of person who cor	mpleted cause of death (Item	23a) (Type, Pr	ئسفا ا		1 0 1	1		
	Stat	e_	Mohammad 1: 31. Date filed (Month, Day, Year)	32. Registrat's Signat	D. 100	DE. Cal	rroll S	t. Salu	sbury, n	1021801	
	Registra		JIII 1 2 20	12	4 4	Company of			/		

DHMH 17 Rev 1/2001

12-05054

Uganda Patrice Schoolfield

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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	400		Thought .	1000	9	-	-	-

	1- For State Registrar		Certific	cate of	Death			Re	g. No.		
Physician/	1. Decedent's Name (First, Mic							Date of Deat Month	h Day Yea	3. Time of D	
Medical Examine	Uganda Patr	ice School	field					uly 5, 201		" 2045 hi	rs
	4a. Facility Name (if not institu 20 Wendy Court	tion, give street and number	er)	41	o. City, Town, o Pocomoke		of Death		4c. County of Worcest		
Funeral	5. Social Security Number	6. Sex 7. /	Age (In yrs. last bi	rthday)	If Under 1 Ye	ar If Unde	er 24Hrs. 8	. Date of Birt	h(MM/DD/YYYY	9. Birthplace (State	or or
Director	216-90-5927	1 M 2 X F	36	Yrs.	Months Day	ys Hours	Min.	4-20-	-1976	Foreign CountryMD	
any	Usual Residence of Decedent  10a. State 10b. Count	у	10c. City, Town	n or Locatio	n					10d. Inside (	City Limits
ě	. MD Wor	cester	Pocor	malea						1 Yes	2 XNo
Aaryland 28a-f show 1 at once	10e, Street and Number	cester	Pocol	lioke	10f. Zip Code			10	og. Citizen of Wh		
the Maryland is or 28a-f sho tiffed at once	20 Wander Co	<del>.</del>			21851				JSA	,	
ith th	20 Wendy Co	12. Was Decede	ent Ever in U.S.	13 Was	Decedent of H	ispanic Orio	in2 ( Specif			- American Indian, 8	lack
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene.  Int. If item 27 is marked other than "natural", or items 23a or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 Never Married 2			If Ye	s, specify Cuba	n, Mexican			White		idot,
rs afte	3 Widowed 4 LL	or Dates:	ompleted) 16a		s Usuai Occupa		kind of work	done	16b. Kind of Bu		
2 hour "nati	Elementary/Secondary (0-1:				st of working life						
36 hin 73 than rdical		2		anage	er				Harde	es	
5-0036 ed within 72 hour sygiene. other than "natu the Medical Exan Completed	17. Father's Name (First, Midd	le, Last)				18.Mother	's Name (Fir	st, Middle, N	l laiden Surname)	1	
21215-0036 Juld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner. To Be Completed by		urgis				Car	olyn	School	olfield	đ	
D 21 tould d Mer tic ev	19a. Informant's Name/Relatio		19	9b. Mailing	Address (Stre	et and Num	ber or Rura	Route Num	ber, City or Tow	n, State, Zip Code)	1
re, MD 21215 i. 1 and 2 should be file ii. I and 2 should be file if feath and Mental H; if filem 27 is marked o or traumatic event, th	Carolyn Stu	rgis/Mothe							D 2185		
S 1 and St Heal of Heal	20a. Method of Disposition  1 Burial 2 Cremati	on 3 Removal from		of Disposit atory or othe	ion (Name of ce er placeLLC	emetery,	Da	ate	20c. Location -	City or Town, State	
MOFE Pages 1 tent of H int: If i	4 Donation 5 Other				cemati		7-17	7-201	2 Dove	r, DE	
Baltimore, permit. Pages I an Department of Hes Important: If ite	21. Signature of Funeral Servi	ce Lio See		22. Na Ber	me and Addres	s of Facility	917	W. I	sabella	a St.	
E.E.S.	d lornal as			Fur	neral	Home	Sali	sbur	v. MD	21801	
Physician	23a. Part I. Enter the disease, failure. List only one caus		ed the death. Do n	ot enter the	mode of dying	i, such as ca	ardiac or res	spiratory arre	est, shock, or hea	Between C	Onset and
Examiner	Immediate Cause (Final disea			arrh	ythmia					Dea	ath
THE T	or condition resulting in death)	200 10 (01 00 0 001	nsequence of):								
e e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of):								
:	Cause Enter Underlying Caus (Disease or injury that initiated	С									
uted d ansit <b>Examine</b>		Due to (or as a cor	nsequence of):								
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760, ilcate be ex g physician the burial	IF FEMALE:		come of pregnancy	,					23d. Date of	delivery	
687 ertific ding p		I Live birth	-4 ti f -t4t-		I death 3	Ectopic	pregnancy		Month	Day	Year
P.O. Box 68: that the death certifi med by the attending detached for use as it. by Physician.	1 ✓ Yes 2 No 9 L	Inknown 9 Unknown		5 Othe	or (Specify)			<u>_</u>	1		
D. E trithe d ached	Part il. Other significant cond	titions contributing to de	ath but not resultir	ng in the un	derlying cause	given in Pa	rt I.	23e. Did to	bacco use contri	bute to the cause of o	death?
i, P.O. ires that the signed by le detach	Pregnancy							1 Yes	2 No 3	Probably 4 🗸 U	Jnknown
Records, The law requires freate has been signage 2 should be Completed								24a, Was a		Vere autopsy findings	
COT law i has t e 2 sh			-				_	autops	m <u>ed</u> ? d	rior to completion of one	
tal Rectinn: The Certificate Certificate Certificate Be Com		and .			26 Plac	a of Dooth	(Check only	1 Yes 2	No 1	✓ Yes 2	No
Vital ysician; ysician; his certi director	examiner?	Managhal.	tient 2 ER/C	Outpatient		0.0			Residence 6	Other: Scene	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl bertification: To Be Completed by P		28a. Date of Ir	njury 28b.	Time of Inj		ury at Work	, -		ow injury occurre		
ion c tending eath. tor: Ad the fur	1 X Natural 5 Pe	(Month, Day	y,Year)		1	Yes 2	No				
r Atte rer der irecto n by ti	2 Accident Inv	restigation 28e. Place of	Injury - At home, f	farm, street	factory, office	building, etc	c. 28f.			er or Rural Route Nun	mber, City
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune Certification:	Suicide 6 Co	termined (Specify)					1	or Town, St	ate)		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician		Physician: To the best of caminer:On the basis of ex	xamination and/or								
Me G Si Si Si Si Si Si Si Si Si Si Si Si Si	29b, Signature and title of certi	and manner state fier	a.		29c. Licen	se number			29d. Date signe	ed (Month, Day, Year,	)
		1 m. 12			O.C.	M.E.			July 7, 201	2	
_	30. Name and address of per	on who completed cause o	f death (Item 23a)								
		eputy Chief Medical		00 W. B	altimore Str	eet, Balti	imore, Mi	D 21223			
State Registra		012 32. Regist	trar's Signature	back	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Julv 2012 12:17AM HARRY DAVID SHIRLEY Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 236-56-2923 Days Min. Hours 1 🛚 M 2 □ F Director 80 Yrs Ŵ۷ 1/27/1932 28a-f show notified at 10a State 10h County 10c. City, Town or Location Director 10d. Inside City Limits BERKELEY WV GLENGARY 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a o the Medical Examiner must be 4054 APPLE HARVEST DR. Funeral 25421 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BRICK COMPANY **FOREMAN** event, th Be 18. Mother's Name (First, Middle, Maiden Surname) ANNIE ELIZABETH DOHMER 17. Father's Name (First, Middle, Last) Ith and Mental H

27 is marked of

traumatic ever ပ HARVEY SHIRLEY Page 1 and 2 should hent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra TIMOTHY SHIRLEY/SON 200 BANEBERRY LANE, MARTINSBURG WV 25404 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State = 6 7/13/2012 BUNKER HILL CEMETERY Department o Important: If any injury or once. BUNKER HILL, WV 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, colded) alle 327 W. KING ST, MARTINSBURG WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final COPD Onset and Death Ph sician/ chrome Du/ monau disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to lor as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Day Month Year 2 No 9 Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bkeelin encephalopotl coronau 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown acidosis pricumotherax 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Director: After this certificate has autopsy perform performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) Accident Investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number MDD67657 Bor MD 7/10/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANISH DESAI, M.D., 7115 GUILFORD DR, SUITE 202, FREDERICK MD 21704 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 3 0 2012 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene												
			State Registrar	Cer	tificate of D	Death	Reg. No. 2012 2439						
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Chinita  D.	,			2. Date of Dea	Year	(ear 07/1				
والمامو	Medic Examin		Chinita D.  4a. Facility Name (if not institution, give street and number)		raylor  4b. City, Town, or	Location of Death	Vuly		2012	0111	<b>A</b> M		
Same of the last			Prince George Hospital		Chever			4c. County of Death Prince George					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days		8. Date of Birth	1		ace (State or	Foreign		
	Director		217-82-8251	Yrs.			9-15-	60	Mary	**			
	fand fshov dat	to	10a. State 10b. County 10c. Cit	ty, Town or Loc	cation				10	d. Inside City	/ Limits		
	Mary 28a- notifie	Director	Maryland Prince George Dis	trict	Height	s				1 X Yes	2 🗌 No		
	ith the				10f. Zip Code			10g. Citizen of		ry?			
	eath w	Funeral	2213 Seton Way  11. Marital Status 12. Was Decedent Ever in U.S.		20747 Vas Decedent of His	spanic Origin? (Sp	ecify Yes or No-		JSA Ice - America	ın Indian.			
36	fter de , or it amine	þ	1 X Never Married 2 ☐ Married Armed Forces?  1 ☐ Yes 2 ☑ No  If Yes, Give		f Yes, specify Cubar		Rican, etc.)	Bla	ack, White, e				
Ö	ours a stural	Completed	3 Widowed 4 Divorced Year or Dates.					Specif	вта				
15	n 72 h	mple	(Specify only highest grade completed)	(Give k	lent's Usual Occupa kind of work done di O NOT use retired)		king	16b. Kind of E	Business/Ind	ustry			
212	withir rgiene ner tha t, the	Co	Elementary/Secondary (0-12) College (1-4 or 5+)  1 2	Buil	ding Ma	nager	I	eder <i>a</i>	al Go	vernm	<u>ent</u>		
and	e filed ital Hy ed oth	To Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, M	Maiden Surnan					
Ĭ	ould b id Mer mark matic		Randolph W.  19a. Informant's Name/Relationship (Type, Print)	Taylor Syl					Harvey				
Ma	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  Liff item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Ieisha Taylor-Daughter							State, Zip Code)  ts Md 20747			
ore,	of Hear fitem rothe		20a. Method of Disposition 20b. F	Place of Dispos	sition (Name of natory or other place					- City or Town, State			
Baltimore, Maryland 21215-0036	Page tment of tant: If jury or			surre			1-12	Clinto	n MI	)			
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Lineral Service Licentee		Name and Address dams Fu		ome Pa,	Aquas	sco Mo	1 2060	08		
			23a. Part 1. Enter the disease, or complications that caused the destination, or heart failure. List only one cause on each line.	h. Do not ente	r the mode of dying	, such as cardiac	or respiratory arre	st,		Approximate Interval Betwe	een		
,da.,	Phylician Medical	H	Immediate Cause (Final disease or condition resulting in death)	KDIAC	- ARRH	HTHMIA	+			Onset and De	ath		
	Examiner		Due to (or as a consequ	ience of):									
		iner	Sequentially list conditions, if any leading to immediate page 2. Due to (or on a nonsequence page 2. Extract Indiabilities	ienes of:				· · · · · ·					
	cuted nd transit	xam	cause. Enter Underlying Cause (Disease or injury that initiated events c										
_	ate be executed ohysician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequ	ience of):									
760	cate by physics the last the	ledic	d										
( 687	oertif ending use a	N/ne	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Feta		Ectopic pregnancy			23d. Da	ate of deliver	of delivery			
Вох	death the atto	by Physician/Me	In the past 12 months?  1  Yes 2 No 4 Pregnant at time of c		Other (specify)			M	onth [	Day Year			
P.O.	at the ed by t detach	, Ph	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use con	tribute to the	cause of dea	ath?		
S, F	uires th n signe uld be	d be						es 2 🗆 No					
Sorc	w required by special strategies.	Completed					24a. Was ar			sy findings av			
Bec	sician: The law is certificate has k	Som					autops perform	ned?	death?	pletion of cau	ise oi		
ţa	ician; certific rector,	Be	25. Was case referred to medical examiner? Hospital:		26. Pla	ce of Death (Chec	k only one)						
<u>&gt;</u>	r this eral di	e: 10	1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 2 ☒ 27. Manner of Death 28a. Date of injury	ER/Outpatient 28b. Time of	t 3 DOA Other	4 U Nursing H	ome 5 Reside						
ou	ath. rr Afte	icat	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ AccidentInvestigation	injury	work?	/es 2 □ No	28d. Describe how injury occurred						
Division of Vital Records,	or Atter fter de lirecto in by ti	Certificate:	3  ☐ Suicide 6  ☐ Could not be 4  ☐ Homicide determined 28e. Place of Injury - At ho building, etc. (Specify,		et, factory, office		28f. Location (Str City or Town,		er or Rural F	oute Number	,		
	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowl	ladaa daatha	an arranged and the a time a								
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Medical	(Check 2 Medical Examiner: On the basis of examination	y knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  posyrof my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the Com	_	29b. Signature and title of certifier	10 1	29c. License	number		9d. Date signe					
	_ ()		I mp (mot b)	400		3688		JULY	17,0	2012			
	BY-11		30. Name and address of person who completed cause of death (Item  DR GRIFFIN DAVIS 300	23a) (Type, Pr	rint)	De	PILEVE	DIV	MD.	2012	5		
	Stat	е	DR GRIFFIN DAVIS 300 31. Date filed (Month, DJUCar) 18 2012 32. Refistrar's Signat	ure	backet		CHEVE	THI.	· v	20/0			
	Registra	ır	JUL I O ZUIZ KENNIK	P. 19	- Water								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	ate of Ma	aryland		rtment of		and M	lental Hy	giene	201	0 0 00	, ,		
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of	Death		2. Date of De	Reg. No.	4 6435	10					
	Physicia Medic		Donald Gr	ı				July 6	Dav	Year	3. Time of Death 10:19P M	1				
	Examin		4a. Facility Name (if not institution, give street a Anne Arundel Medical				4b. City, Town, Annapol		of Death		4c. County of Death Anne Arundel					
No.	Funeral		5. Social Security Number 6. Sex		(In yrs. la:	st birthday)	If Under 1 Year	If Under		8. Date of Bir	th	g. Birti	hplace (State or Foreign	7		
8	Director		264-22-2298 1 M 2 Usual Residence of Decedent	□ F 88		Yrs.	Months Days	Hours	Min.	(Month, Da 2/26/1			rida			
	and show	tor	10a. State 10b. County		10c. City,	, Town or Loc	ation						10d. Inside City Limits			
	Maryl 28a-f lotifie	Director	Maryland Anne Arunde	L	Anna	apolis							1 □ Yes 2 X N	0		
	ith the										Ü	n of What Coi	untry?			
	eath w	Funeral	1000 Jigger Court  11. Marital Status 12. W	as Decedent Ev	ver in U.S.	. 13. W	21401 /as Decedent of Yes, specify Cub	Hispanic Ori	igin? (Spec	cify Yes or No-		Race - Amer		_		
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	a Dagazza de Deixande de le	med Forces? Yes 2 □ N ′es, Give ar or Dates.	No WW	TTI	Yes, specify Guil			Rican, etc.)	Spi	Black, White ecify; Whi				
2-0	hours natur dical B	olete	15. Decedent's Education (Specify only highest grade com	1			ent's Usual Occu ind of work done		t of workir	na	16b. Kind	of Business/I	ndustry	_		
21215-0036	ithin 72 ene. • than '	Completed		llege (1-4 or 5+	+)	Sales	NOT use retired	daning mos	it of works	ig	Pharm	aceuti	cals			
nd 2	filed wall Hygi al Hygi al other went, 1	Be	17. Father's Name (First, Middle, Last)							(First, Middle,				Т		
Maryland	uld be d Menta markec natic e	To	Unknown						oroth		adwe11			4		
	12 should lith and Me 27 is marl r traumati		19a. Informant's Name/Relationship (Type, Printer Patricia Tyson/Wife	IE)			g Address (Stree Jigger (						Code)			
Baltimore,	of Heal		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Remov	al from State	20b. Pla	ace of Dispos	sition (Name of latory or other pla			ate		tion - City or	Town, State			
ti m	it. Page rtment c rtant: If njury or		4 Donation 5 Other (Specify)	L TOTT GIALE	Kal	as Cre	matory Name and Addr		7/9/	2012	Edgew	ater,	MAryland	_		
Ba	permit. Departr Importa any inju		21. Sign the of Funeral Service Licenses	5.									MD 21037	J		
ľ	HE.		23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.  Approximate Interval Betwee													
ja .	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.  Due to (or as a consequence of Ventricular Testing Indian Sequence of Ventricular Testing Indian India													
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m	sit sit	Examiner	cause. Enter Underlying	erice Oi).												
	execute n and ial-tran	Exal	Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events c. Due to (or as a consequence of):											$\neg$		
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corc	aw requas bee	plet								24a. Was auto	osy	prior to c	ere autopsy findings available or to completion of cause of			
Ä	sician: The law certificate has t director, page 2 s									1 Yes	ormed? 2 X No	death?	2 🗆 No	_		
ita	Physician: T this certifice and director, p	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospita	l: . <del>[/</del> ]		R/Outpatien		her:	-	h (Check only one)						
Division of Vital Records,	his h	ate: To	27. Manner of Death 28	a. Date of injury (Month, Day,	y [:	28b. Time of injury	28c. Inju wo	iry at rk?	2	-	dence 6 Other (Specify)					
sion	I or Attending P safter death. I Director: After the in by the funera	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	. Place of Injur	ry - At hon	ne, farm, stre		Yes 2		28f. Location (5	on (Street and Number or Rural Route Number					
DIV	tal or / rs after al Dire		1								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	Hospi 24 hou Funer etely fil	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: On	the basis of ex	amination	and/or investi	gation, in my opir	nion, death or	ccurred at	the time, date a	and place, an	d due to the c	ause(s) and manner stat	ed.		
		2	only one) 3 Certifying Nurse Prac 29b. Signature and title of certifier	7	nest OLILI	y Knowledge,	29c. Licen	se number	1		29d. Date s	igned (Month	, Day, Year)	$\neg$		
	ÉD		Mes es	5			Du	(337.	5		7/6	12		_		
	4+1		30. Name and address of person who complete Karen W. Merritt, M.]		ath (Item :	, , , , ,	rint) A	me	2 1	700 1 1	noon	el a	C Stay			
	Stat Registra		31. Date filed (Month, Day, Year)  JUL 10 2012	32. Registrar	r's Signatu	A be	we !		, 76	7		1 1 13	-7-71			

				Type or Pi										ible.				
		•	For AMEN #26 per PHY State //10/2012 AACO Registrar	HEALIH DEP	r. MH	Cer	tificate o	of De	eath	and ivi	Cintairiy	Reg. N	20	12	24	394		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  2. Date of Death											Year	3. Time of	Death		
· more	Medi	ai		Burton Thorman  Facility Name (if not institution, give street and number)								4 2	2012		11:5	5 p <sup>M</sup>		
	Examir	ier	Bay Woods Of				4b. City, Town			of Death			c. County		ndal			
	Funeral		5. Social Security Number 6. Se		ge (In yrs. Ia	st birthday)	If Under 1 Ye	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th	T	9. Birth	olace (State o	r Foreign			
	Director		Usual Residence of Decedent	XM2□F	95	Yrs.	I World I Do	.,,	riodis				Country) L 1916 New Y			rk		
	land show dat	tor											-	0d. Inside Ci	ty Limits			
	Mary 28a-f otifie	irec	Maryland Anne A	rundel	A	nnapo									1 🗆 Yes	2 <b>X</b> No		
	ith the	Funeral Director	10e. Street and Number	Dr. Ant	. 122		10f. Zip Coo	<sub>de</sub> L 4 0	12			10g. C	Citizen of W US		itry?			
	ems (ems	nue	7101 Bay Front  11. Marital Status	12. Was Decedent	Ever in U.S		Vas Decedent o	of Hisp	panic Orig	gin? (Spec	ify Yes or No-		-		an Indian,			
980	72 hours after death with the Maryland n "natural", or Items 23a or 28a-f show the a Examiner must be notified at	ρ	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 X Yes 2 If Yes, Give Year or Dates.	- 1	f Yes, specify C ☐ Yes 2 <b>X</b> ☐				ican, etc.)			k, White,	etc.				
9-0	2 hours off "natural", "Is a Exer	lete	15. Decedent's Ed	lucation		16a. Deced	lent's Usual Oc					16b.	Kind of Bu					
21215-0036	高温	Completed	(Specify only highest gra	College (1-4 or		life. D	kind of work do O NOT use retir	red)	ring most	t of workin	g		nited States 1			Dept		
d 2	Hygie Hygie other ant, th	BeC	12th 7yrs Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, M							(First Middle		Jus		ce				
lan.	l be fill fental rked rtic eve	뎯	Emanuel Thorman	ı							e Kur		i Surname,	,				
Maryland	should and N is ma auma		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	g Address (Stre	eet an	d Numbe	er or Rural	Route Numbe	Route Number, City or Town, State, Zip Code) 21403						
e,	and 2 Health am 27		Rose Thorman (William) 20a. Method of Disposition	lfe)			Bay F		nt 1			r				d		
Baltimore,	permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thi any Injury or other traumatic event, the once.		1 ☐ Burial 2 【X Cremation 3 ☐		e ce	emetery, cren	sition (Name of natory or other)	place)		-	ate 1 2		Location -	•				
altin	mit. Parantmet oortan injury		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service License		Me		remato	_		7-6- v 192					Md.	ie		
ä	permi Depar Impor any ir		Lavy Bi Bee	40		Wn	ı. Rees	se	& S	ons	Mortu	ary	, P.	A.	Md.	2140		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a insequence of):											Approximate Interval Between Onset and Death						
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987	artifica ding ph	/Me	IF FEMALE:	23c. If yes, outcom	o of progner			_					-					
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate by 24 hours after death. After this certificate has been signed by the attending physic truerel Director: After this certificate has been signed by the attending physic stely filled in by the funeral director, page 2 should be detached for use as the b	Completed by Physician/Medio	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 4 Pregnant 9 Unknown	2 Fetal at time of d	death 3	Ectopic pregn Other (specify					Ì	e of deliventh	•	⁄ear			
P.O.	requires that the der been signed by the s should be detached	by P	Part II. Other significant conditions co			alting in the u	nderlying cause	e giver	n in Part I	l.	23e. Did t	obacco	use contri	bute to th	e cause of de	eath?		
rds,	een sig	eted	Typer	reusi	~		-				1 🗆	Yes 2	2 (L/No	3 🗌 Prol	ably 4 🗆 I	Jnknown		
Division of Vital Records,	To the Hospital or Attending Physician: The law naturin 24 hours after death.  To the Funerel Director: After this certificate has be completely filled in by the funeral director, page 2 si	omple		-							24a. Was auto perfo	psy ormed?	, a	rior to co eath?	sy findings a npletion of ca	vailable ause of		
a	ian: T ertifica ctor, p	BeC	25. Was case referred to medical examiner?				26	8. Place	e of Deat	th (Check o	1 🗌 Yes	2131	<u>10</u>	☐ Yes	2 🗆 NO			
Ξ	Physic this ce al dire	욘	1 ☐ Yes 2 ☑ No  27. Manner of Death			ER/Outpatien	LOUDOA		_4 L Nu	rsing Horr	e 5 D nesi	<del>dence</del>	6 XOther	(Specify	HVIII			
n O	iding f th, After funer	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of inj (Month, D	ay, Year)	28b. Time of injury		vork?	nt es 2□	- 1	3d. Describe h	now inju	jury occurred					
isio	27. Manner of Death  1  Natural 5  Pending  29. Accident Investigation  3  Suicide 6  Could not be determined 1  Homicide								8f. Location (S			or Rural	Route Numb	er,				
ă	oltal or urs aft rel Dir illed in	City or Town, State)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
	Hosp 24 ho Fune etely f	Medical	(Check 2 L. Medical Examir	ner: On the basis of	examination	and/or invest	igation, in my or	pinion.	death oc	curred at the	ne time, date a	and plac	e. and due	to the cau	se(s) and mai	nner stated.		
	To the within 2 To the comple	2	only one) 3 Certifying Nurse 29b. Signature and title of certifier	e Fractitioner: 10 t	ne best of m	y knowledge,	29c. Lice			e and plac	e, and due to		ate signed					
	.~		) James Cle	rene		me	L	>1	69	64			7-	5-	201	2_		
	好成人		30. Name and address of person who co	ompleted cause of		23a) (Type, P	rint)	1-	A	+~~	20	1	u p	> 2	101	~		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Régist	rar's Signatu		and	1	•			)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>D</sup>2012 July Nancy Thomas 8 Medical 3:30 A M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Mary's Hospita St. Mary's Leonardtown Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Days Aug. 17 Hours Director 66 231-58-2219 1945 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City Town or Location Director 1 Yes 2 No Marvland St. Marv's Lexington Park 10f. Zip Code 10g. Citizen of What Country? Funeral 22611 FDR Blvd. Apt# 220 20653 USA 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John William Duvall Ruth Summerville Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Jeffery Thomas/ Son 20a. Method of Disposition Balsam Way, Great Mills, MD. 20634 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 12, 2012 Waldorf, MD. Huntt Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. He-morrhoge Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** quartially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hypertonsidn the burial-tran that initiated events Due to (of as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death Month detached 1 L Yes 2 L 9 D Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) of 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Division 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D060473 081 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20650 DINT COOKOUT

State

Registrar

31. Date filed (Month

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			AMEND #24,	Se Type or Pri PER MD G930 State of M	nt in B 8/30 arvland	lack Ir 12 Ti 7 Depa	ndelib RT artmer	le Ini	<b>c. Ens</b> lealth	ure A	II Copie Iental Hy	s Ar	e Leg	ible.	0.1	0.0	
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	Physicia	an/	1. Decedent's Name (First, Middle	•		2. Date of Dea Month							ay	Voor	3. Time o	f Death	
A-0	Medi	cal	NANCY	N. TAWI	ES						July	12,	20	-	6:26	A M	
÷	Exami		4a. Facility Name (if not institution, 220 S. Somerse  5. Social Security Number	Avenue	- //	4 6 2 4 7 - 1 - 2		Cris	field	E			some:	rset			
	Funeral Director		215–30–4225 Usual Residence of Decedent	e (In yrs. last	Yrs.	If Unde Months	Days	If Under Hours	Min.				9. Birthp Count Mar	Birthplace (State or Foreign Country) Maryland			
	laryland 8a-f show ified at	Director	10a. State 10b. County 10c. City, Town or Location  Maryland Somerset Crisfield									···		1	0d. Inside C	ity Limits	
	with the N 23a or 28 ust be not	Funeral Dir	10e. Street and Number 220 S. Somerset	Avenue			10f. Zip	Code 218	17			10g. C	itizen of W	/hat Coun			
9600	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 🛣 Marri 3 ☐ Widowed 4 ☐ Divorced	ied 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ▼ If Yes, Give Year or Dates.		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black							k, White, e	American Indian, White, etc. Vhite			
21215-0036	thin 72 ho ene. t <b>han "na</b> l <b>he Medi</b> ca	Completed	15. Deceden (Specify only higher Elementary/Seconday (0-12) 12	College (1-4 or 5		life. DC	kind of woi D NOT use	rk done d e retired)	ation uring most	t of workir	ng		Kind of Business Industry				
73	be filed within 7 ental Hyglene. <b>ked other than</b> c event, the M	Be	17. Father's Name (First, Middle, La Harold Creston N	*	18. Mother's Name (First, Middle, Maiden Surnam							OWN I					
ary	should be file and Mental F is marked o raumatic eve		19a. Informant's Name/Relationsh		Т	19b. Mailin	g Address	(Street a				Route Number, City or Town, State, Zip Code)					
Σ,	nd 2 s ealth a m 27 i	1	Arthur W. Tawes,	Jr. (Husba	nd)	220 5	s. so	mers	et Av	enue	- Cri	sfie	ld, 1	MD 21	817		
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp		cerr	ce of Dispos netery, crem LLY CE	natory or o	ther place	<b>)</b>	_	5/2012	ı	ocation -	,			
Balt	permit Depart Import any inj once.		21. Signature of Fugeral Service	uas //	1	22. Br	. Name an	d Addres	s of Facility Sons	Fun	eral H	ome					
	Robert H. Bradshaw, 18. 306 W. Main St Crisfield, MD 2181  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):											Approximate Interval Betwoen and E	ween				
	cate be executed physician and sthe burial-transit	Sequentially list conditions, if any, leading to immediate the first thing in death) Last  Due to (or as a consequence of):															
. Box 68760	ith certifi ttending or use at	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Un									23d. Date of delivery Month Day Year			ear			
ls, P.O.	uires that the dea n signed by the a uld be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									id tobacco use contribute to the cause of death					
Division of Vital Records,		Completed			24a. Was an autopsy fi prior to complet death?  1  Yes 2 No 1 Yes 2 C						pletion of ca	vailable ause of					
ta .	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					26. Plac	ce of Death	n (Check		2 220 140	01 1	L les 2	140		
<u> </u>	di S	욘	1 Yes 2 No	Hospital:  1 Inpatie	nt 2 ER				4 LI Nui	rsing Hon	ne 5 Resid	dence 6	Other	(Specify)			
ion o	After After fune	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigs 3 Suicide 6 Could no	b. Time of injury	М			- 1	28d. Describe how injury occurred								
Divis	fo the Hospital or Attending Phymithin 24 hours after death.  To the Funeral Director. After the completed filled in by the funeral		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								8f. Location (8 City or Tow	n, State)	)			er,	
:	n 24 ho n 24 ho ne Fun pleted	Medical	(Check 2' Medical Ex	aminer: On the basis of ex	amination an	nd/or investic	aation, in n	noiniao vn	<ul> <li>death occ</li> </ul>	curred at t	he time, date a	nd place	and due t	o the caus	e(s) and man	ner stated.	
i	vithi Voithi Comp	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month															
	SL			Un t	-47			7 /	1800	78		71	12/1	2			
_	78		30. Name and address of person when the Vijay Karumbuna					wav -	. Cri	sfie	Id. MD	2181	17				
1	Stat Registra	е	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1. 6		,				<u> </u>	. /				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JÜĽŸ 7. JOSEPH A. VENDEMIA, SR 5:20 PMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 23 Winslow Court Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F 1072871935 Washington, DC 76 217-32-0253 **Director** Usual Residence of Decedent Show 10a. State 10b County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Maryland 1 X Yes 2 □ No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 23 Winslow Court 21403 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or Homer any injury or other trainments. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Was Decedent Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Barber Hair Styling/Cutting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Angelo Vendemia Paiano Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Vendemia, Jr./Son 23 Winslow Court, Annapolis, MD 21403 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 7/10/2012 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home alax Solomons Island Road, Edgewater, Md. 21037 23å. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last but to (or se a consequence or, Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and de detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performe Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 
Nursing Home 5 Residence 6 - Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 - Pending work? 2 🗆 No within 24 hours after death

To the Funeral Director: / Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie P

Registrar

49

eld Rd, Suite 8, Severna Parly MD 21146

cause of death (item 23a) (Type

Registrar's Signat

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
Emily Watson 2. Date of Death 3. Time of Death July Physician/ 2012 6:00pM Medical 4a. Facility Name (if not institution, give street and number)
Chester River Hospital 4b. City, Town, or Location of Death Chestertown Examiner 4c. County of Death Kent . Age (In yrs. last birthday) 66 8. Date of Birth (Month, Day, Year) 03-4-1946 If Under 1 Year If Under 24 Hrs Funeral 80 4765 6 Sex 9. Birthplace (State or Foreign Hours 1 - M 2 XF **Director** S.C show Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and one. 10d. Inside City Limits Oc. City, Town or Location Centreville Director Oueen Anne MD 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 302 East Water Street 21617 Funeral ÚSA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Completed by 1 Never Married 2 Married Yes Yes, Give Page 1 and 2 should be filed within 72 hours after Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Private Elementary/Secondary (0-12) 12th College (1-4 or 5+) Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Watson ည Eva Pinkney 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3555 Promenade Place #324 Waldorf, MD 20601 Norma Pullen / daughter 20c. Location - City or Town, State Beltsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 07/18/12 chesapeake Crem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf MD 20601 21. Signature of Funeral Service UCOL. ONCE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bun. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 🗌 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 2 [**X**No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work 1 Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title o 29d. Date signed (Mor 30. Name and address inpleted cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

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31. Date filed (Month

Year) 8 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Thomas Washington State of Maryland / Department of Health and Mental Hygiene 2012 24400 1- For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day July 12, 2012 Year **Medical Examiner** 1657 hrs Thomas Washington Sr 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11108 Cross Road Trail Brandywine Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs, last birthday) **Director** Days Hours Foreign CountMaryland 1 2 M 2 F 69 217-42-7888 Yrs 1-9-1943 Usual Residence of Deceden nv 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahor
injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Prince George Brandywine Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11108 Cross Trail Rd 20613 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No 3 Widowed 4X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mechanic Auto 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) å Thomas Davis Marie Ι. Washington ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5716 Eagle St.Capitol Heights MD 20743 Thomas J Davis Jr-Son 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify 7-21-12 Heritage Cem. Waldorf, Maryland 21. Signa re of Funeral Service Licer 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Retween Onset and /Medical Death a. Shotgun Wound of Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury Jul 12, 2012 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Subject shot 5 Pending 1 Yes 2 ✔ No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 11108 Cross Road Trail, Brandywine, MD determined (Specify) Residence 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 13, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month) Da 32. Pegistrar's Signature Ye1'8 20

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Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 12 Day 2012 Year 10:30 P M Edythe WAGANHEIM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Bedford Court Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director 579-22-5046 1 🗆 M 2 🛛 F 86 Yrs. Sept. 19, 1925 New York Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 3005 S. Leisure World Blvd., #511 Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked ot r other traumatic ever ဂ Anna Egelko Max Peck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 3005 S. Leisure World Blvd. #511, Silver Spring, Gilbert Waganheim, Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 X Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden Falls Church, VA 21. Signature of Funeral Se Torchinsky of Hebrew Funeral Home M01008 St. NW. Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 Months Immediate Cause (Final Physician/ disease or condition resulting in death) Pancreatic Carcinoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) ng physician and a as the burial transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse ( 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Month Day Year Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has death? performed? Yes 2 V No 25. Was case referred to medical the Hospital or Attending Physician: funeral director, Be 26. Place of Death (Check only one) examiner? 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? within 24 hours after death.

To the Funeral Director, Aft completely filled in by the fun Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 23958 July 13, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

t I. Feldman, M filed (Month, Day, Year) 2012 3305 N. Leisure World Blvd., Silver Spring, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 29D, PER MD G929 7/31/12 TRT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MATTIE WADDELL :02P 2012 Medical Jul 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manor Care - Ruxton Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Country) 7/4/1923 213-38-8591 Director 1 □ M 2X□ F 89 28a-f show 10c. City, Town or Location death with the Maryland 10a State 10b. County 10d. Inside City Limits notified at Director Baltimore Owings Mills MD 1 🗌 Yes 2 ី No 10f. Zip Code ritems 23a or 10e. Street and Number 10g. Citizen of What Country? ò Funeral 4728 Wainwright Circle 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite Black, White, etc ş 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Yes 2 Typic White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Campbell Mae Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Waddell/Daugh. 4728 Wainwright Circle, Owings Mills, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel Air Mem.Gdns 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/14/12 Bel Air, MD 21. Signature of Finance rvice 22 Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA C. Kover 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. It only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Demon Medical resulting in death) Due to (or as a consequence of): **Examiner** Dizensi 60 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran and physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 No should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of death? page 2 performe Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Chack only one) examiner? 2 / No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours Medical 29a. Certifier Certifying Physician) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

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completely fi on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ٥ 7/25/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 31 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia dical Exami		Decedent's Name (First, Middle,L Garry	ast) White					2. Date of Dea Month July 11, 2	ith	Year	3. Time of Death 0507 hrs
}		4a. Facility Name (if not institution, game 1712 Poplar Grove Street	give street and number)		1	y, Town, or	Location of Death			County of Death	0007 1113
Funeral Director		214-66-2964		(In yrs. last i		nder 1 Year	+	s. 8. Date of Bir	th (MM/I 3/19!	DD/YYYY) 9. Birt Foreig Ca. OI	nplace (State or n District untry) Columbia
iow any		Usual Residence of Decedent  10a. State 10b. County  MD	1		wn or Location Ltimore						10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 1712 Poplar Gro	ove Street R		10f.	Zip Code	16	1	0g. Citiz	en of What Coun	
death with t or items 23s	ıneral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent E Armed Forces?		13. Was Dece	edent of His	panic Origin? ( S , Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Americ White, etc.	can Indian, Black,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	ted by F	15. Decedent's Education (Specify	ed If Yes, Give Year or Dates:		1 Yes a. Decedent's Usu during most of	ial Occupati				Specify: Bl	ack
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	Completed	Elementary/Secondary (0-12) 11 17. Father's Name (First, Middle, La		)	Carpent		18.Mother's Name	e (First, Middle, I		ilding	
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MD 2 d 2 shoul lith and M n 27 is m	ř	Fannie White / M			422 McB	ride I	Lane Se			y or Town, State, MD 2114	
imore Pages 1 ment of H tant: If it or other											
Balt permit Depart Import		21. Signature of Funeral Service Lice	ensee		Barra 495 R	nd Address NCO & itchie	Sons, P	.A. Seve	erna	Park Fu Park, M	neral Home
Physician /Medical		23a. Part . Enter the disease, or confailure. List only one cause on	nplications that caused the each line.	e death. Do							Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent		Cardiova	iscula	r Diseas	se	<u> </u>		Death
	iner	Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause	Due to (or as a consequence.	uence of):							
ted J ansit	Examiner	events resulting in death) Last	Due to (or as a consequent	uence of):							
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burfal - transit	cian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day									
O. BC	Physic	Part II. Other significant conditions	9 Unknown	out not result	ting in the underlyi	ng cause gi	ven in Part I.	23e. Did to	bacco u	se contribute to the	ne cause of death?
S, P.O. luires that the signed by a signed by all be detached.	ed b)	Chronic Alcohol	Abuse								ably 4 Unknown
tal Records cian: The law requi certificate has been ector, page 2 should	Completed by		<u> </u>					24a. Was a autop perfor	sy med?	prior to co	opsy findings available impletion of cause of
Vital Rec hysician: The l this certificate	e Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient	2 ER/	/Outpatient 3		of Death (Check		Residen	ce 6 🗸 Other:	Scene
ion of tending Phelath.  Item: After to the funeral	Certification: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investiga	28a. Date of Injury (Month, Day,Year	288	o. Time of Injury		y at Work?	28d. Describe h	now injur	y occurred	
Divisital or A area after or all Direct Inches Inch	ertific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or or Town, State)									al Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only 1 Certifying Physi	cian: To the best of my ker:On the basis of examinand manner stated.								
H S H S	¥	29br Signature and title of certifier	111	1 84		9c. License O.C.M				ate signed <i>(Mont</i>	h, Day,Year)
2		30. Name and address of person who Zabiullah Ali, M.D. Ass	completed cause of dea sistant Medical Exa	, , , , , ,	,	ore Stree	et, Baltimore,	MD 21223	'		
∖ St Regist	ate rar	31. Date filed (Month, Day Year)	2012 32. Registrar's	Signature	1. par	1					
	_										

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. Lity, Town, or Location of Death Examiner 4c. County of Death Social Security Number If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 7964 1 M 2 D F Hours Min. Maryland Director 87 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Salisbury Maryland Wicomico 1 X Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21801 USA 1101 Frederick Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Armed Forces?

1 Armed Forces? 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🙀 No 3 Midowed 4 ☐ Divorced Specify Specify: Completed White Corps Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Advertising Sales **WBOC** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hazel Hitchens Issac Wingate Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Long Wharf Rd., Salisbury, Maryland 21804 Cynthia Gore daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 07 | 12 | 2012 | Salisbury, Maryland 21. Signature of Funeral Vivice Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd., Sailsbu J. Sailsbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASOVI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has page 2 s autopsy performed?

Yes 2 No death? 2 No 1 🗌 Yes the funeral director, Be ( 25. Was case referred to medica 26. Place of Death (Check only one) examiner? ဂ္ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work ☐ Accident 2 No Investigation 24 hours after deatl Funeral Director: Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Cortifying Nurse Praction of T. The Leaf of Tyling Angles of the Cortifying Nurse Praction of T. The Leaf of Tyling Angles of the Cortifying Nurse Praction of T. The Leaf of Tyling Angles of the Cortifying Nurse Praction of T. The Leaf of Tyling Angles of the Cortifying Nurse Practice of Tyling Angles of the Cortifying Nurse Practice of Tyling Angles of Tyl (Check within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) N61 847044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA 5- DIVISION Steer StelsBURY 1415 49 21804 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7 Year 11:48 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PARK ADVENTIST HOSPITAL ASHINETON TAKOMA MONTEUMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 237661899 Hours (Month, Day, Year) Director 1 🕱 M 2 □ F 03 31 show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: I frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits HALIFAX HOLLISTER 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27844 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 📈 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Wildowed 4 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MECHANIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HITESTONE DRIVE STAFFORD AWRENCE 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Surial 2 Cremation 3 Removal from State SREATER LOVERY HILL CEMETER 4 ☐ Donation 5 ☐ Other (Specify) 07-16-2012 21. Signature of Funeral Service Licensee

21. Signature of Funeral Service Licensee

21. Signature of Funeral Service Licensee 22, Name and Address of Facility
BIANCHI FUNERAL SERVICE
814 UPSHUR STREET NEW W. . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician ACUTE MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CORONARY ARTERY Securifically 4st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ been signed by the atte should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death g Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KEWAL FAILURE Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown HY PER TENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No the Hospital or Attending Physician: The thin 24 hours after death.

the Funeral Director: After this certificate by 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pending injury 2 Acciden
3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number JOB 210 D40324 JULY 9, 2012

DHMH 17 Rev 06-2011

Registrar

Registrar's Signature

7600 CARRELL AVENUE, TAKOMA PARK, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERRY JODRIE, MD, FACEP

31. Date filed (Month, Day, Yea

1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Ma	arvland	Department of H	lealth and N		niene.	cgibic.	01105
			1 = For State Registrar	Otato of Mic	arytaria /	Certificate of			Reg. No.	012	24406
	Physici		1. Decedent's Name (First, Middle	R - Chelle	Ac	Ree		2. Date of Dea	ath Day	Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution	give street and number)	1/6		or Location of Death	Jarry	4c. C	county of Death	-/
			5. Social Security Number	6. Sex 7. Add	e (In yrs. last		MOI-C If Under 24 Hrs.	8 Date of Birt	'h	NA	lace (State or Foreign
	Funeral Director		220-78-3921	1 □ M 2 X F	52	Yrs. Months Days	Hours Min.	8. Date of Birt (Month, Da	y, Year) 9	Coun	LD
	/land ow at		Usual Residence of Decedent  10a. State 10b. County	. 1	10c. City, To	own or Location	-			1	0d. Inside City Limits
	e Man 3a-f sh	ctor	MD N	IA	Bal	timore					1 X Yes 2 □ No
	with the	Funeral Director	10e. Street and Number	a Aug		10f. Zip Code	1206		10g. Citize	en of What Coun	ntry?
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and	be filed ntal Hygi ed other	Be C	17. Father's Name (First, Middle,	Last)		DI FCOHONACT	18. Mother's Nam	e (First, Middle,	Maiden S	umame)	City
	Mer Mer arke	To E	Greekge L.  19a. Informant Name/Relations.	HCree		9b. Mailing Address (Street	Martha	- Jane	Fo	24 Ker	Codol
, Mary	d 2 s th ar 7 is trau		Latrece T.	Gaines-1	Daughte	= 6989 MC	Clean Bl	vd. B	altim	Ore, M.D	21234
Baltimore,	- I 0 =		20a. Method of Disposition 1  Burial 2  Cremation	3 □Removal from State	20b Place ceme	of Disposition (Name of other plantery, crematory or other planter)	сө) 7/2	Date	20c. Loca	ation - City or To	wn, State
	C 00 -1		' 4 □Donation 5 □ Other (S		Uh	SITE CHEME 22. Name and Addre	iss of Hacility	1 1 Jane	WY+	Imore,	MI)
ñ	permit. Departimport any inj		Vimite	K. Jme		HOLE IN	Jorth A	ve. B		more, 1	10 21202
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X D	that the death certifica ed by the attending ph detached for use as th	lan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal dea		1		23	ry Day Year	
j.	by the a	Physicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of death	5 Other (specify)		Month Day Year			
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_	The ate h page	Сотр			-			autop		prior to con death? 1 ☐ Yes	npletion of cause of
VII	Physician: r this certific ral director,	o Be (	25. Was case referred to medical examiner?	Hospital:		Outside ST Do. Oth	26. Place of Deat	2			
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2	tal or A s after at Direct	Certification;	4 Homicide determ		f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attending Phys within 24 hours alter death.  To the Funeral Director: After this completely filled in by the funeral directors.	edical (	29a. Certifier 1 Certifyin (Check only one)	examiner: On the basis of	examination.	dge, death occurred at the tir and/or investigation, in my o	pinion, death occur	red at the time.	date and n	lace, and due to	the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
			Neha Illes	peinesso	2	23	267	Ĺ	July	26,2	2012
			30. Name and address of person Debra S Wes	theiner	eath (Item 23a 70	3700 Loch	Rawen 1	Blud.	Bal	to. Md	21218
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 0 1 2	37. Registra	ar's Signature	29c. Licens D 23  (Type, Print)  3900 Loch					
	-1091011		NUU V A C	VIL JOHN							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:50 PM omas Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice OWSON Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Director 1 XM 2 □ F ox permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No OFF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/230 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 X Yes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working ife DO NOT use-retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) /Secondary (0-12) College (1-4 or 5+) Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ laggie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Non-smal cancel disease or condition resulting in death) year Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 Other (Specify) \( \text{VOSPLE} 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral o 28a. Date of injury (Month, Day, Year) /8c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

AARON

AUG 0 1 2012

31. Date filed (Month, Day, Year)

6701

N.

HARVES

Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24408 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ALLISON 09:22 AM ILLY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Director 68 212-42-6301 1 □ M 2 🛛 F Usual Residence of Decede Feb 27, 1944 Maryland 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes 2X No Sykesville MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21784 3989 Robin Hood Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) secretary other traumatic event, Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hw.
Important: If item 27 is meriany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pearl Agnes Dill Edward Aaron Shepherd 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 3989 Robin Hood Way; Sykesville, MD 21784 Herbert Allison - husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) fure of Funeral Service t 21. Sign 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD Part 1. In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SROSI Medical Due to (dr as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pendina Accident Suicide Investigation s after death filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29h Signate re and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

30

31. Date filed (Mo

RES-000

1800 ORLEANS ST BALTIMORE MD 21287

JULY 27, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician Vear Rebecca Anderson JULY 2.30 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Levindale Hebrew Geriatric Center & Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐ F Director 219-38-9491 90 NC Jul 28, 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified Directo 1 Yes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Pennsylvania Avenue 21201 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any Injury or other traumatic event, the Meagnes. Elementary/Secondary (0-12) College (1-4or 5+) **Daycare Provider Private** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Thomas Alderman** ပ္ Blanche Faison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8252 Streamwood Drive Pikesville, MD 21208 Julia Anderson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Jul 28, 2012 Brooklyn Park, Md. Cedar Hill Cemetery & 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that can be did the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart? liure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE BARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Por in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed: certificate 1□ Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1.XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062895 JULY 2012

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Month, Day, Year)

AUG 0 1 2012

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY 2012 05:02A M ANBINDER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death OAK CREST VILLAGE PARKVILLE BALTIMORE 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days (Month, Dav. Year) Hours 214-24-8310 **Director** 1 □ M 2 🕅 F 83 01/18/1929 Usual Residence of Decedent MD 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 X No MD BALTIMORE PARKVILLE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral 23a 8800 WALTHER BLVD 21234 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. If Yes, Give Specify: An binden Myrg 3 X Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **ISADORE** LAPIDES ETHEL FOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 ROBERT ANBINDER / SON 2423 SYLVALE ROAD, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL CONG. 07/31/2012 BALTIMORE, MD 21. Signature of Funeral Service Liversee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complicator's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one this eon each line. Immediate Cause (Final disease or condition Onset and Death Physician/ bronacu Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Day Month Year Yes the P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate Yes 2 N 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other 1 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation the Funeral Director: Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. indexided in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Discritiving Nurse Practitioner: To the best of my knowledge, death one illined at the take. date and place, and due to the 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) son w Harrison CRNP 8800 WOLTHER Blud Parkville NO 21234 State Registrar

DHMH 17 Rev 06-2011

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		Good Samaritan Hosp  5. Social Security Number					Baltimore	or If Lindo	a Odles I	O Data of D	Pioth (NANA/D)	N/A	Birthplace (S	into an
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, MD 2:215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relations			1	_	Address (Stre					,		)
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		25. Was case referred to medical					26.Place	e of Death (	Check only	<u> </u>	2140	1 🗸	Yes 2	No No
Vita bysich this ce	To Be	examiner?  1  Yes 2 No	Hospital: 1   1	npatient	2 🗸 ER/	Outpatient	3 DOA	Other <sub>4</sub>	Nursing H	ome 5	Residenc	e 6 🗌 O1	her:	
1 of ling Ph		27. Manner of Death  1 Natural 5 Death	28a. Date of Jul 26, 2	of Injury Day Year)	28b	. Time of Inj 53 hrs		iry at Work?	S.	d. Describe bject sho		occurred		
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Divi	ertification:	3 Suicide 6 Could not be determined (Specify) Local Street (Specify)										lumber, City		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	O	29a Certifier	ysicien: To the best			eath occurre	ed at the time, d	ate and plac						
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	ž	29b. Signature and title of certifie	000				29c. Licens						Month, Day, Ye	ear)
		Poti Un-	Toller		· ·		O.C.	M.E.			July 2	7, 2012		
A) [		<ol> <li>Name and address of person Patricia Aronica-Pollal</li> </ol>			,		00 W. Baltir	nore Stre	eet. Balt	imore M	ID 21223	3		
St	ate	31. Date filed (Month, Day, Year)	32. R	giswer's S					, <del></del>					
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DHMH 17 Rev 1/20	001		-		0	RIGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5, 20a-c, 22 per fh g930 8-8-12 yt State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 18, 2012 Robert Brett Bronaugh 7:41 PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7417 Lynnhurst Street Chevy Chase Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours 65 Director 1 X M 2 □ F 213-48-5760 1947 Usual Residence of Decedent April 23, Maryland ms 23a or 28a-f show must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🔀 No Chevy Chase MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20815 7417 Lynnhurst St. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or ð 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: white "natural", Completed 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' jury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) 12 media consultant self employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Frank H. Bronaugh Mary Eleanor Brett 19a. Informant's Name/Relationship (Type, Print) ing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 01d Creek Ct; Rockville, MD 20854–5529 Deborah E. Richey - cousin 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Crem Department of Important: If any injury or 4 Donation 5 X Atlantic Crematory 8-3-12 Glen burnie, Md 22. Name and Address of Facility State Anatom Cremation & Euneral Services Anatomy Board Simplicity Rona1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or hear failure. List only one cause on each line. Md. 21076 Thomas Allen PA Interval Between Immediate Cause (Final OBSTRUCTIVE PYLMONARY DISEASE Onset and Death Physician/ CHRONIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 2 X No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 \( \text{Yes} 2 Accident
3 Suicide
4 Homicide 2  $\square$  No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 026571 of person who completed cause of death (Item 23a) (Type, Print) MD 10605 CONCORDST

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $\mathbf{J}_{\mathbf{u}}^{\text{Month}}$ 23 ay 2012  $P^{\mathsf{M}}$ Jeanne Louise Bolinger 9:30 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 18877 McKay's Beach Road Leonardtown St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Hours 316-40-2797 72 Director 1 □ M 2 X F Usual Residence of Deced July 4, 1940 Indiana 28a-f show 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No St. Mary's Leonardtown MD 10e. Street and Number 9 10f. Zip Code Citizen of What Country? 10g. er than "natural", or items 23a or the Medical Examiner must be Funeral 20650 USA 18877 McKay's Beach Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) dental hygienist healthcare and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Emma Louise Taylor Winfrey Bertline Myers other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 shart of Health a 20650 18877 McKay's Beach Rd; Leonardtown, MD Benjamin M. Bolinger - husband Department of Heal 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 4 X Donation 8 Other (Specify) 22. Name and Address of Facility State Anatomy Coard Functor Sary Signature Wade ecto 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician OVARIAN CARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner EAKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed and trar Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Yes 2 No Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ျ 1 🗋 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 □ Nursing Home 5 ★ Residence 6 ★ Other (Specify) ₩SP1 ( € funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death.

I Director: After the in by the funeral 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after

To the Funeral Direct

completely filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and cause of death (Item 23a) (Type, Print)

State Registrar 20945 GREATMILLS RP, LEXINGTON PARK, MD 20653

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of M	larylan		artment of H		Viental Hyg	giene	2 21.1.11.			
Dlava		,	Registrar  1. Decedent's Name (First, N.	, ,				reain	2. Date of Dea		3. Time of Death			
	edica	ı I	As Escility Name (if not instit	Abraham Bre	ought	on, Jr				1 21, 2012 Year	18:00P M			
Exa	mine	r	,	5 South Paca Street			4b. City, Town, or	Baltimore		4c. County of De	N/A			
Fune Direct	tor		5. Social Security Number 248-56-8907 Usual Residence of Decede	1 M 2 □ F	ge (In yrs. Ia <b>76</b>	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct 13	of Birth h, Day Year) ct 13, 1935  9. Birthplace (State or Foreign Country) SC				
laryland 3a-f shov ified at		ector	10a. State 10b. County 10c. City, To			, Town or Lo	cation	Baltimore		10d. Inside City Limits 1 ☐ Yes 2 ☐ No				
ith the M 23a or 28 st be not			10e. Street and Number 2655 South Paca	Street			10f. Zip Code	21230		Country?				
21215-0036  within 72 hours after death with the Maryland giene.  et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	:	Completed by Funeral Director	11. Marital Status  1  Never Married 2  3  videowed 4  Divo	12. Was Decedent Armed Forces? 1 Yes 2 X		li li	√as Decedent of His Yes, specify Cubar ☐ Yes 2 ☐ No		ecify Yes or No- Rican, etc.)	cify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify:  Black				
:1215-( Ithin 72 hou ene. • than "natu the Medica		complet	15. Dec (Specify only I Elementary/Secondary (0- 12	cedent's Education highest grade completed)  -12) College (1-4 or	5+)	(Give F life. D	ent's Usual Occupa ind of work done du O NOT use retired) <b>Heavy Equip</b>	uring most of work			nd of Business/Industry			
land 2 be filed w ental Hygi ked other ic event, t		ωŀ	17. Father's Name (First, Mide	dle, Last)  Abraham Broug	ıhton S	r.		18. Mother's Nam	1 /	e (First, Middle, Maiden Surname)  Julia Addison				
Maryland 2 should be file th and Mental   7 is marked of traumatic eve			19a. Informant's Name/Relat  David Broughto	tionship (Type, Print)		19b. Mailin	g Address (Street at South Paca	nd Number or Rur <b>Street, B</b>	City or Town, State, 2 D 21230	Tip Code)				
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1	20a. Method of Disposition	ation 3 🗆 Removal from State		emetery, crem	sition (Name of atory or other place		Date <b>27, 2012</b>	20c. Location - City o	n Town, State n Park, Md.			
Balti permit. Departr Importa	once.		21. Sign up funeral Serv	vice Licensee	7	22	Name and Address Estep Bro 1300 Euta	of Facility others Funeral w Place Balt	Il Service, P. imore, Md 21	A. 217				
ate be executed whysician and the burial-transit	cal ner	Ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
. Box 6876  ne death certificat  y the attending ph  ched for use as th	Oblinio (Mos	iysiciaii/iwec	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome  1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
Division of Vital Records, P.O. Box 68760  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit	omolotod by	23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part i.									Probably 4 Unknown utopsy findings available completion of cause of			
of Vital   Physician:   Physician:   this certifica	E C	200	25. Was case referred to med examiner?  1 Yes 2 No  27. Manner of Death	Hospital:		ER/Outpatient	3 DOA Other	4 ☐ Nursing Ho	ome 5 Reside	ence 6 Other (Spe				
Division of Vital tal or Attending Physician: rs after death. al Director: After this certific ed in by the funeral director.	t confined	Celtilicate	1 Natural 5 Pe 2 Accident Inv 3 Suicide 6 Co	(1.4 11 - 15 -	y, Year) ury - At hom	injury			28d. Describe ho	reet and Number or Ri	ural Route Number,			
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Modioo		(Check 2 ☐ Medic only one) 3 ☐ Certif	cal Examiner: On the basis of e fying Nurse Practitioner: To th	xamination	and/or investi	occurred at the time, date and place, and due to the cause(s) and manner as stated, stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner s, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
Notice To t		2	29b. Signature and title of cer	T Durus	MD		29c. License r	16256	29	9d. Date signed (Mon 7/24/	th, Day, Year) 2012			
		$\perp$	BICH DU	son who completed cause of d			der c	horce	lare.	Baltin.	2012 re 100 21228			
S Regis	State strar	3	AUG 0 1 201		ar's Signatu	re May								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/  $\overset{ ext{Month}}{ ext{JULY}}$ 30 TOBA 2012 BURSTYN 1:15P Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6513 WICKFIELD ROAD BALTIMORE BALTIMORE Social Security Number 9. Birthplace (State or Foreign Country)
POLAND If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 🗆 M 2 🕱 F Hours 0871571924 Director 218-52-0104 Usual Residence of Decedent 28a-f show 10a, State the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 6513 WICKFIELD ROAD 21209 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER FOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည RACHMAN SZANDLA CHATT . Page 1 and 2 should ment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRY BURSTYN / SON 2833 SMITH AVENUE, #118, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) LUBAWITZ NUSACH ARI 07/31/2012 ROSEDALE, MD 21. Signature Jun Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final et and Death Physician. gespre hu month Medical resulting in death) Due to (or s/ consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit Exami Due to (or as a consequence of): physician the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months?
1 Yes 2 No jo Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. signed by the best of the signal of the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes .2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No page certificate | 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 **Z** No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? Certificate: 5 Pending injury 1 Yes 2 No Accident Suicide M neral Director: A Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

X DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day,

29d. Date signed (Month, Day, Year)

12-05632 Jacob Cochran Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 24416

		1- For State Registrar		Ce	rtificate of	Death				Reg. No			
		1. Decedent's Name (First, Midd	lle,Last)			•		2.	Date of De		Vee		3. Time of Death
edical Exam	iner	Jacob Andrew (	Cochran						Month July 28,	Day 2012	Year		1044 hrs
		4a. Facility Name (if not institution	on, give street and n	umber)	4	b. City, Town, o	r Location of	Death		4	c. County o	Death	
		Upper Chesapeake M	ledical Center		İ	Bel Air				[1	Harford		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs,	ast birthday)	If Under 1 Ye	ar If Under	24Hrs.	8. Date of E	Birth(MM	I/DD/YYYY)		hplace (State or
Director		219-47-7657	1 <sup>X</sup> M 2 F	1	_5 Yrs.	Months Day	s Hours	Min.	Sen	25	1996	Foreig Cou	n untry)Maryland
		Usual Residence of Decedent	10.111						Bep.	23,	1000		
пу		10a. State 10b. County		10c. City	, Town or Location	on .						1	10d. Inside City Limits
0W a		Manual and Han	£3										1 Yes 2 No
Maryland 28a-f show any d at once,	to		ford		. Air								
Mary 28a dat	Director	10e. Street and Number	ill Dood			10f. Zip Code	D			-	tizen of Wha	at Coun	itry?
Sa nr	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-										5A		
with ms 2.													can Indian, Black,
leath r ite											White,	etc.	
fler (I", o		3 Widowed 4 Div	vorced If Yes, Give Ye		1	Yes 2 X No	specify:				Specify: [	Specify: White	
2 hours after "natural", Examiner	d by	15. Decedent's Education (Spe		ide completed)	16a. Decedent					16b.	Kind of Bus	iness/Ir	ndustry
72 ho	ete	Elementary/Secondary (0-12)	College (	1-4 or 5+)		st of working life	e. DO NOT us	se retired	1)	1			
than than	ldu	11			Stud	ent					Privat	te S	school
d wi	Completed	17. Father's Name (First, Middle	, Last)				18.Mother's	Name (F	irst, Middle	Maider	Surname)		
11215-0036 Id be filed within 72 hours after Aental Hygiene. narked nither than "natural", event, the Medical Examiner	Be (	Christopher 1	Lamar Coc	hran			Chris	stine	e Mich	ele	Watso	on	
ID 21215-003 should be filed within and Mental Hygiene. It is marked other the matic event, the Med	To	<u> </u>											Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene sant: If item 27 is marked inther than "natural", or items 23a nr 28a-f she or other transmatic event, the Medical Examiner must be notified at once.	-	William Watso	n / Grand	father									nd 21015
and and lealth		20a. Method of Disposition			Place of Disposit		metery,		ate	20c.	Location - 0	City or 1	Town, State
Org ges 1 t of 1		1 Burial 2 Cremation		om otato	crematory or oth		0.1	0 /1	/2017		D - 1 3		Maran 1 a 7
Page men tant		4 Donation 5 Other S		Be	el Air M				/2012				Maryland
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		22. Signature of Meral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A											
		1317 Cokesbury Road, Abingdon, Maryland 21  23a. Part I. Effet, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate											
Physician		failure. List only one cause on each line.  Immediate Cause (Final disease a. Contact Gunshot Wound of Head  Between Onse Death											Approximate Interval Between Onset and
/Medical Examiner													Death
,	or condition resulting in death)  Due to (or as a consequence of):												
	Sequentially list conditions, b												
	Examine	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause											
	lam	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence o	f):								
ecuted and transit	9		d										
ਲ ਦੀ ਦ	edical	UNPENDED	AMENDED										
8760, ificate be ext ig physician is the burial -	Vec	IF FEMALE:	23c. If yes.	outcome of preg	nancv					23	d. Date of d	eliverv	
187 Tuffica		23b. Was decedent pregnant in the past 12 months?			2 Feta	il death 3	Ectopic p	regnancy	/		Month		ay Year
Sox 687 leath certifi e attending	<u>;</u>		· -	nant at time of de	ath 5 Oth	er (Specify)							
Be e dea	Physicia	1 Yes 2 No 9 Uni	9 0116										
P.O.	by P	Part II. Other significant condit	tions contributing t	o death but not r	esulting in the un	derlying cause	given in Part I	I.					he cause of death?
res that signed									1 Ye	es 2 💽	<b>/</b> No 3 _	Proba	ably 4 Unknown
rds requ been hould	Completed								24a. Was				opsy findings available
e law	밁									ormed?	de	ath?	empletion of cause of
tal Recian: The certificate ector, page	ပို	05 Mar				00 PI-	(5 " (0)		1 Yes	2 N	0 1	Yes	2 No
ician ician s cert recto	Be	25. Was case referred to medica examiner?	Hannital:	Innations Of	ED/Outrations		of Death (CI			10		0.11	
of Vital Records, ag Physician: The law require this certificate has been sineral director, page 2 should be	၉	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2	28b. Time of In		ry at Work?	Nursing H			ury occurre	Other:	
n of ding Ph	ë	1 Natural	Lu (Mont	Day Year)	0940 hrs		Yes 2 ✓ N	Su	bject sh			_	
SiOr of death ctor: y the	E		stigation										
Division tal or Attendir rs after death. al Director: A led in by the fu	\$		d not be	e of Injury - At h		factory, office b	ouilding, etc.	28	<ul> <li>f. Location or Town,</li> </ul>		and Number	or Rur	al Route Number, City
<u>ra</u> g <u>ra</u>	Certification:	4 Homicide	rmined (Specify,	Single Fan	nily Home			202	25 Ruffs N	lili Róa	d, Bel Air,	MD	
the Hospi hin 24 hou the Funer npletely fil	Ea	(Cincont Ging)	hysiclan: To the be										
To the Hos within 24 h To the Fur completely	edic	one) 2 Medical Exa	miner:On the basis and manner:		nd/or investigatio	n, in my opinior	n, death occur	rred at th	e time, date	and pla	ace, and du	e to the	cause(s)
F 5 F 3	Σį	29b. Signature and title of certifie				29c, Licens	e number			29d.	Date signed	(Mon	th, Day, Year)
O.C.M.E.										July	29, 201	2	
581	ŀ	30. Name and address of person	who completed cau	se of death (item	23a)								
1 0	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223												
2	ate	31. Date filed (Month, Day Year)	32. R	egistrar's Signat	ire								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month :28A M 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HIMOre 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. 9-16-1919 1 M 2 W Hours Country) ns Yrs. **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No timore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Newer Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Yes. Give Specify. Completed 3 ₩Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. 90 NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Mide ည rand-20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Lic md 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ptomician/ Demento disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to Immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day 5 Other (specify) Month Year Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed certificate 1 Yes To the Hospital or Attending Physician: within 24 hours for deeth.

To the Funeral Pirector. After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes ဂ္ A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: Natural 5 Pending 2 Accident
3 Suicide 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and certifier M.D. D72536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUMIT BAUTANI 821N Enton Street duit 302 Daltina MP UMIT 32. Regist ar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 12 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ CARL CHRISTIAN DEDERER, JR. 2013 12:25AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City. Town, or Location of Death Joseph Medical Center Towsor Baltimore 8. Date of Birth (Month, Day, Year) May 13,1933 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Numbe 9. Birthplace (State or Foreign Hours 219-30-0311 79 Director 1 K M 2 D F MD. or 28a-f show 10h County 10a. State 10c. City, Town or Location death with the Maryland must be notified at 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 ☐ Yes 🗶 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21206 609 Elmwood Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o þ 1 Never Married 2 Married 1 Yes 2 X No
If Yes, Give
Year or Dates. White 1 Yes 2 X No Specify: Specify "natural" Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Supervisor other than Elementary/Secondary (0-12) College (1-4 or 5+) Tax Maps Assessment 12 yrs. Maryland State Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ျှ Carl Christian Dederer. Sr. Esther Virginia Stamm Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn L. Dederer (Wife) 609 Elmwood Rd. Baltimore, Maryland 21206 mportant; If item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 8-4-2012 Baltimore, Maryland 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Signature of Funeral Service Licensee any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Providen/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undanying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ idium Difficile 1 Yes 2 No 3 Probably W Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 death? After this certificate 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 1 X Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after deatl To the Funeral Director: completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 0 29c. License number 0 D46356 Maris who completed cause death (Item 23a) (Type, Print) 30. Name and address 1601 Osler Drive Towsor 21204 laba M.D. Md (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHARLES STEWART DIEGEL 2012 JÜLY 7:35A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON GILCHRIST HOSPICE 8. Date of Birth July 17, 1939 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 9. Birthplace (State or Foreign Director 216-36-1866 1**X**XM 2 □ F 73 MD. Yrs 27 is marked other than "natural", or items 23e or 28a-f show traumatic event, the Medical Examinar must be notified at 10a. State within 72 hours after deeth with the Maryland 10h Count 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 USA 3612 Galloway Rd. 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2NX No Specify: If Yes, Give Specify:White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Should be filed within 72 hend Mentel Hygiene. 7 Is marked other than "n 12 yrs. Mars Grocerv Food Industry æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roberta Curran John Jacob Diegel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 3612 Galloway Rd. Baltimore, Md. 21220 Dolores Diegel (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place)
Holly Hills Cemetery 1 D Burial 2 Cremation 3 Removal from State 8-2-2012 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 21. Signature of Funeral Service Licenses 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to or as a consuluence of Exami To the Hospital or Attending regreement within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and To the Funerel Director. After this certificate has been signed by the attending physician and To completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🗶 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Chec only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20071787 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip & haven, 670 N. Challes Challes St. \* 4105, Baltinare, MD 21204

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

AUG 0 1 2012

Box 68760

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5,15,16a-b,20a-c,22,per fh,g930 8-1-12 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kourtney Dunston MC Medical 4a. Facility Name (if not institution, give street and number or Location of Death 4c. County of Death Examiner pry/ana ultimore 8. Date of Birth If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs **Funeral** Month Day, Hours Min <sup>Year)</sup> 2012 Maryland N/A Director 1 □ M 2 💢 F July Usual Residence of Decedent 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21217 1429 Riggs Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Was Decedo... \_ Armed Forces? 1 ☐ Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc 1 X Never Married 2 Married þ Specify: Black Saltimoré, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the -INFANT INFANT INFANT N/A N/A INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ciarra Perkins Robert Dunston other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1429 Riggs Avenue; Baltimore, MD 21217 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ciarra Perkins - mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State On-Site 8/20/2012 Baltimore, MD 4 Donation 5 N Oth Anatomy Board March F/H West 22. Name and Address of Facility State Anatomy 5655 4300 Wabash Ave., Baltimore, Mp. 3 Signature of Euneral Stryice Licensee Ronal d St. Wale Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the burial-tran resulting in death) Last attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ been signed by the atter should be detached for u in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospita Other: ည 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's Signature State AUG 0 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ ouglas 2012 :20p 07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 73 216-36-2744 Director 1 □ M 2 🖔 F DC 31 40 05 Vre 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b County must be notified at Director 1 X Yes 2 No Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò U.S.A. Funeral 23a 21215 3520 Manchester Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status an "naturai", or ite Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Black þ 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes. Give Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Baltimore City College (1-4 or 5+) Elementary/Secondary (0-12) Public Schools the Teachers Aide 2th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown and Mental item 27 is marked other traumatic ev ည Page 1 and 2 should be 1 nent of Health and Menta Hennietta Presley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Md 21117 Green Mountain Ct., Owings Mills, Frederick Douglas-Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 8/1/2012 Baltimore, Md On-Site 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West Baltimore, Md 4300 Wabash Ave, 23a. Part 1. Enter the disease, or a molicutions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ urrent over disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to manufacture cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown tor; After this certificate has been si the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes Be 26. Place of Death (Check only one) 25. Was case referred to medical Other: 2 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated B Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Sign 10059014 PHYSICIAN ted cause of death (Item 23a) (Type, Print) WASHINGTON 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clayton Ross Eveland, Jr. Month <sup>Day</sup> 2012 July 29 3:45 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 9320 Washington Blvd. Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days **Director** 203-28-6571 1 🗶 M 2 🗆 F 76 March 8, 1936 Pennsylvania Usual Residence of Decedent show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Lanham 1 ☐ Yes 2 K No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 9320 Washington Blvd. 20706 U. S. A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married 1 Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1954-56 other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) AT & T Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clayton Ross Eveland Hazel Lucille Dalby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1. anham. Maryland 20706 of Health and N item 27 is ma 19a. Informant's Name/Relationship (Type, Print) Sylvia S. Eveland/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 

Burial 2 

Cremation 3 

Removal from State 8/1/2012 4 Donation 5 Other (Specify) Waldorf, Maryland Huntt Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 1002 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ metastatic Adeno careinome - unknown primary 4 months Medical Examiner Sequentially list conditions, Dunito for as a nonsequence of: if any heading to impedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? n signed by the at lid be detached fr Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perfor death? certificate Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗙 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0030484

29d. Date signed (Month, Day, Year)

6188 OXON Hill Rd #704 OXON HILL, MD 20745

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 July Antoinette 22 1:55 PM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Catonsville Baltimore St. Martin's Home Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) 9 / 9 / 1 9 1 7 1 🗆 M 2 🗶 F Hours 94 Haiti **Director** 121-40-4653 Usual Residence of Decedent show 10a. State within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Catonsville 1 🗌 Yes 2 🏻 No MD 10e. Street and Number 10g. Citizen of What Country? Funeral 601 Maiden Choice Lane 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important. If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Physical Therapist Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Corine Picard Champana Bernard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5209 Eliots Oak Road, Columbia, Maryland 21044 Rose-Marie St. Jean / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Tonation 5 X Other (Specify) Entombment Gate of Heaven 7/28/2012 Silver Spring, MD ure of Funeral Servi 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e In line. Immediate Cause (Final Onset and Death Physician/ disease or condition Week Medical resulting in death) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown page 2 should be detached been signed by the 9 Unknown Part II. **Qther significant co**nd**itions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 ☐ Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ပု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkens Ave Baltimore 3455 31. Date filed (Month, Day, AUG 0 1 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 07:30 PM 28 SYLVAN **EDELSON** 0 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 12 M 2□ F 88 047-12-0696 04/06/1924 MD Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1X Yes 2 No Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 2434 W. BELVEDERE AVENUE 21215 USA Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ASSISTANT ENGINEER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be i **EDELSON** ٩ ESTHER SAVAL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHILIP EDELSON/BROTHER 184 LUDLOW ROAD, MANCHESTER, CT Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
ANSHE EMUNAH AITZ
CHAIM CEMETERY Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/31/2012 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Sonice License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMENTIA Physician resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause [Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩hknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ours after death.

neral Director: /
filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or within 24 hours at To the Funeral D La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10064533 2012 MYSIGAN - 30 -

Registrar

State

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31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

BELVEDERE

2434 W.

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BALTIMORE

AVENUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE GENERALL

MI

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25+ Stonth 20 Physician/ Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE Center 100050N If Under 1 Year If Under 24 Hrs.

Months I Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Sex **Funeral** Days 1 □ M 2 🗡 F Director 46 10d. Inside City Limits end 2 should be filed within 72 hours after death with the Maryland Health and Merital Hyglene.
tem 27 is marked other then "naturel", or items 28e or 28e-f show ther traunatic event, the Modical Exercises must be notified at 10b. County 10c. City, Town or Location Director 1 ¥ Yes 2 ☐ No A HIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21224 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces?, 1 Never Mamied 2 Married þ 1 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates INDIA 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) WORKER Domestic 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TARRAGON Koad-Keistertown f Health IENNE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 e
Department of F
Importent: If ite
eny injury or ot 1 Bunal 2 Cremation 3 Removal from State PAHIMARE NETRO 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WANCY M. WALLACE 21. Signature of Funeral Service Licensee FUNERAL NANCY M FARAKIA Street Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breas Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physicien: The lew requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): erel Director: After this certificate hes been signed by the attending physiclan filled in by the funeral director, page 2 should be detached for use es the buna Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2 No 2 🗆 No 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Yes ၉ 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death Certificate: injury 1 Natural 5 - Pending 1 ☐ Yes 2 ☐ No death. Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after deat Funerel Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certific within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one natura 29b. Si F851 F000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 4105, Baltimore 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

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Physician Medica	/ il	Registrar  1. Decedent's Name (First, Middle, Last)  Da Vi A  4a. Eacility Name (if not institution, give street and number)	G,	pson		2. Date of Death	2 No. C. U   Year 201:	3. Time of Death				
Funeral Director		The Johns Hopkins 5. Social Security Number 6. Sex 7. Ag 219-86-7498 1 1 1 M 2 1 F	HUSPITOL e (In yrs. fast birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	g. B	ath N/A irthplace (State or Foreign ountry) MD				
Maryland 28a-f show otified at	Director	Usual Residence of Decedent  10a. State  10b. County  MD  BaltImore City	10c. City, Town or Lo	peation	Baltimore			10d. Inside City Limits				
with the 23a or st be no	Funeral D	10e. Street and Number  3225 Avon Avenue		10f. Zip Code	21218	10	g. Citizen of What C <b>U.S</b>					
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yland 2 d be filed v Mental Hyg arked othe attic event,	9	17. Father's Name (First, Middle, Last)  James Gips	on		18. Mother's Name		Maiden Surname) ease Gipson					
Mar.		19a. Informant's Name/Relationship (Type, Print)  Alease Gipson		ing Address (Street Avon Aven		Route Number, Ci	City or Town, State, Zip Code)					
Baltimore, bermit. Page 1 and Department of Hea mportant: If item any injury or other once.		20a. Method of Disposition  1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro C	matory or other place crematory, inc	Aug 0	1, 2012	20c. Location - City or Town, State  Catonsville, Maryland					
Ball permit Depart Impor any inj		21. Signature of Funeral Service Licensee	2	2. Name and Addre Estep Br 1300 Eut	ss of Facility others Funeral S aw Place Baltim	Service, P. A. ore, Md 2121	7					
Physician/ Medical		23a. Part First the disease, or complications that caused shock, or heart failure. List only one cause on each liny Immediate Cause (Final disease or condition resulting in death)  a. Due to cause	e death. Do not ent	er the mode of dyir	ng, such as cardiac or	respiratory arrest,	,	Approximate Interval Between Onset and Death				
Examiner		Sequentially list conditions, b.	a consequence of):									
be executed ician and burial-transit		that initiated events C.	a consequence of):									
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Division of Vital Records, P.O. Box 68760 for the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Modical Certificate. To Be Completed by Divisional Modical Certificates.	Ilysiciali/ivi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	23d. Date of d Month	elivery Day Year								
been signed by the at should be detached is should be detached in the standard by the at should be detached in the should	Lea ny L	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.			to the cause of death?  Probably 4  Unknown				
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Vital hysician: his certific	200	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	ent 2  ER/Outpatie	Oth	lace of Death (Check o	only one)		7.1				
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after cleath. To the Funeral Director, After this certificate has been sig completely filled in by the funeral director, page 2 should Medical Certificate. To Re Completed.	icale.	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	ry 28b. Time o	f 28c. Injur	y at 28	ne 5 🔲 Hesideno Bd. Describe how	ce 6 Other (Spe	icity)				
Division Attention Attention By the Control of the				t home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
he Hospita in 24 hours he Funeral spletely filler	Sinak	29a. Certifier (Check conly one)  1 Certifying Physician: To the best of the b	xamination and/or inves	stigation, in my opini	on, death occurred at t	he time, date and p	place, and due to the	cause(s) and manner stated.				
To the with common comm		29b. Signature and title of certifier  Elizabeth King	MD	RE E	5-000	) 29d	i. Date signed (Mon	th, Day, Year) 27, 2012				
9		30. Name and address of person who completed cause of d Elizabeth King	eath (Item 23a) (Type   1800 0	Print	St Bal	timore,	MD. 2	1287				
State Registrar		AUG 0 1 2012 Security St.	ar's Signature									
DHMH 17 Rev 06-201	11		• •									

Sready Havold 239-202 Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Franklin Harold Gregory /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Levindale Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F 229-22-2021 Director 04 04 29 83 ٧A Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show show 1X Yes 2 No MD NA Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 3 must be n U.S.A. 3215 Dorithan Road 21215 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner me 11 Marital Status Black, White, etc. ty Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver M.T.A. 12th grade 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eliza Laws John Frank Gregory 27 is marked traumatic e 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Gregory-Wife 3215 Dorithan Road, Baltimore, Md 21215 item 27 other t Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h ortant: If i 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) On-Site 7/31/2012 Baltimore, Md 21. S making of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or hear allure. List only one cause on each line. Immediate Cause (Fmal disease or condition resulting in death) Physician leumonia /Medical Due to (or as a consequence of Examiner ascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 Tes 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signatore and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day Year,

AUG 0 1 2012

12-05628 Jarrad Gladden

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 24428

		1- For State Registrar	ate of Maryland /		tificate		th	Montan	r, g.o.i.c	eg. No.	401	6 6 4 4 6	
Physici Medical Exami		Decedent's Name (First, Middle		ladd	en, <del>-</del>	Sr.		<u> </u>	2. Date of Dea Month July 28, 2	Day Y	rear .	3. Time of Death 1137 hrs	
		4a. Facility Name (if not institution St. Agnes Hospital	, give street and number)				Town, or Lo	cation of Dea	th	4c. County of Death			
Funeral Director		5. Social Security Number 219-02-9092 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth Foreign Foreign Cou											
т апу		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Baltimore										10d. Inside City Limits 1 Yes 2 No	
th the Maryland 23a or 28a-f shn notified at once.	Director	10e. Street and Number				10f. Zi	p Code		1	0g. Citizen of			
with the sa 23a or be notifie		3008 Normour	12. Was Decedent 8	ever in U.		Vas Deced			Specify Yes or No		ice - Americ	can Indian, Black,	
after death ral", or iten	by Funeral		orced If Yes, Give Year or Dates:	X No	1 Yes 2 No specify:					Specif	hite, etc. <sub>y:</sub> Bla		
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28s-f shur traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specific Elementary/Secondary (0-12) 12th	ify only highest grade comp College (1-4 or 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Barber  Self Em								
21215-00 Id be filed wit Aental Hygien marked other event, the M	Be	17. Father's Name (First, Middle, I	dden Sr.					Nancy	e (First, Middle, Millia	ams			
MD 2. 12 should th and M 127 is m.	10	19a. Informant's Name/Relationsh Denise Gladde							Rural Route Num Balto				
Baltimore, MD 2 bernit. Pages I and 2 shou Department of Health and N important: If Item 27 is in njury nr nther traumatic		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Spe		e c	Place of Disp rematory or inity	other place	)		Date 3,2012	20c. Locatio			
Baltimore permit. Pages I Department of I Important: If		21 Signat Funeral Service Licensee 22 Name and Address of Facility Calvin B. Scruggs Funeral Home										21213	
Physician Medical Examiner		Approximate I add the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate I Between Ons										Approximate Interval Between Onset and Death	
LAMIIIIEI	or condition resulting in death)  Due to (or as a consequence of):  Deep Leg Vein Thrombosis												
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consect.  Due to (or as a consect.)										
760, icate be executed physician and the burial - transit		events resulting in death) Last	d			1	0-						
'60, ate be ex physician he burial	Medical	X UNPENDED  IF FEMALE:	X AMENDED #1 p			b,pt.	11,27	per m	e,g930 8	-6-12 s			
tox 68 eath certif	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkr	4 Pregnant at t	me of dea	_ =	Fetal death Other (Spe	_	Ectopic pregn	ancy	Month	D	ay Year	
, P.O. Entres that the designed by the		Part II. Other significant condition Atherosclerot			•		g cause give	n in Part I.				he cause of death?	
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  1 Director: After this certificate has been sited in by the finneral director, page 2 should the finneral director, page 2 should the finneral director.	Completed by	Methadone Use								sy med?	prior to co	opsy findings available ompletion of cause of	
Vital Reco ysician: The lar his certificate ha	Be Co	25. Was case referred to medical examiner?						Death (Check	1 Yes :	2 No	1 Yes	s 2 No	
n of Vit ding Physic I. After this of funeral dire	유	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	<del>/ T</del>	ER/Outpatie 28b. Time o		28c. Injury a		ng Home 5 28d. Describe h				
Division pital or Attendin ours after death. reral Director: A	Certification:		igation not be (Month, Day,Ye		me, farm, str	eet, factor		2 No			nber or Rur	al Route Number, City	
E G D		4 Homicide determ		- knowledg	e, death occ	curred at the	e time, date	and place, an	or Town, S		ner as state	d.	
To the How within 24 h	Medical	one) 2 Medical Exam 29b. Signature and title of gertifier.	niner: On the basis of exam and manner stated.	ination an	nd/or investig		y opinion, de c. License n		at the time, date			th, Day, Year)	
$\mathbf{D}_{V}$							O.C.M.I			July 29, 2		,, ==,	
is bound occur			Deputy Chief Medic	al Exam	niner 90	0 W. Ba	ltimore S	treet, Balti	more, MD 21	223		8	
St	ate	31. Date filed (Month, Day Year)	32. Registrar	signatur	back	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Cen ruenebaum 20:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOWARD HOWARD COUNTY GENERAL HOSPITAL COLUMBIA Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours (Month, Day, Year) Director 579-40-3734 1 🗆 M 2 🛛 F Usual Residence of Deceden 78 12/27/1933 DC show ms 23e or 28e-f short must be notified at 10a. State flied within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 🔯 No HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10812 SYMPHONY WAY 21044 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🖾 No Specify Specify: WHITE 3 ☐ Widowed 4 🔀 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ei Hygiene. I other then ' UNITED JEWISH College (1-4 or 5+) Elementary/Secondary (0-12) 1 2 BOOKKEEPER APPEAL FEDERATION æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ISRAEL LIEBERMAN FANNY WORON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 i CAROL PELON / DAUGHTER 36 BOYD STREET, WATERTOWN, MA 02472 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION, INC 08/01/2012 HAMPSTEAD, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Sonature of Funeral Service-Licens 8900 REISTERSTOWN ROAD, MD 21208 PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition Medical resulting in death) Due to fr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sicien end buriei-trensit Exami Due to (or as a consequence of): signed by the ettending physicien d be deteched for use es the burie Physician/Medical or Attending Physicien: The lew requires that the deeth certificete be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The iew require within 24 hours after death.

To the Arel Brector After this certificate has been sit completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify, 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of etrtifier 29d. Date signed (Month, Day, Year) D64874 2012 1an1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

AUG 0 1 2012

arks

Ci

32. Registrar's Signature

HCGH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month gam 0935A M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital of Baltimore Sinai Baltimore ati If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 212-30-9166 Director 1 🗆 M 2 🗷 F S.c. 1933 10 10a, State 10b. County within 72 hours after death with the Maryland iral", or items 23e or 28a-f sho Exemples must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WOLFE 21213 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ "natural", or 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 ₩ Widowed 4 □ Divorced other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) BALTIMORE CITY BUS ASSISTANT 12 Ith and Mental Hygie
27 is marked other
traumatic event, if Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rant: If item 27 is marked BRICE 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BATIMORE, Md. 21213 WOLFE ST. HALL OHNNY Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Important: If if eny injury or c 1 🕽 Burial 2 🗌 Cremation 3 🗌 Removal from State 8/6/2012 Baltimore, Md SARRISON FOREST 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNGRAN SWS PA 21. Signature of Funeral Service YORK Road. Baltimore, Md. 21212 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Betwe Priset and Death Severe Metabolic Acidosis Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Failure Acyk Renal Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying un Known Exami Peripheral VASICIAN ate has been signed by the attending physician and page 2 should be detached for use es the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Lectopic pregnancy Day Pregnant at time of death 5 Other (specify) Yes 2 ☐ No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an Hypertension autopsy performed? 1 Yes 2 No corman Artery Disease this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funerei Director: After this certification completely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my position, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 Rosetta Ella Marie Holmes 9:00 A M 28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1 Sulky Ct. Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/3/1960 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 🛭 Hours 218-84-0437 Director 51 MD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Baltimore Randallstown 10e. Street and Number 10g. Citizen of What Country? Funeral 1 Sulky Ct. #204 21133 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 No þ Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Black 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Algie Bailey Viola House t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark njury or other traumatio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erica Holmes-Daughter 3749 Brice Run Rd #F Randallstown, MD 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 8/2/2012 OwingsMills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityMarch F/H- East 1-82/h 1101 E. North Ave. Baltimore, 21202 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Year the g | Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of 24 hours after death.

Funeral Director: After this certificate has leted filled in by the funeral director, page 2 s autopsv Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined ca 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or 29b. Signati

DHMH 17 Rev 7/2009

Registrar

Date filed (M

AUG 0 1 2012

onth, Day,

Baltinove, MD 21204

of person who completed cause of death (Item 23a) (Type, Print)

p. Shaheen, 6701 N. Charles St. # 4105,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item Ide per In 8930 8-1-12 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ GLADYS ELIZABETH HALL JÜLY 4:30A 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON GILCHRIST HOSPICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours 1 □ M 💆 🖺 F Director 214-14-7346 \$ept. 14,1922 VA. 89 Yrs. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

The 21st marked other than "natural", or items 23a or 28a-f show often traumatic event, the Me As or Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Baltimore County Baltimore 1 ☐ Yes XX No Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number #2215 Oakcrest Funeral 8810 Walther Blvd. Orchard Village Apts. USA 21234 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed, College (1-4 or 5+) 12 yrs. U.S. Coast Guard Administration Be 18. Mother's Name (First, Middle, Maiden Surname) Effie Simpson 17. Father's Name (First, Middle, Last) မ John Suthard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3410 Groveton St. Alexandria, Va. 22306 Brenda E. Hall (Daughter) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ot NX Burial 2 ☐ Cremation 3 ☐ Removal from State 8-2-2012 Parkwood Cemetery Baltimore, Md. 4 Donation 5 Other (Specify) Lassahn Funeral Home 21. Ig atur of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Baltimore, Md. 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami been signed by the ettending physician and should be detached for use as the burial-transit Physician: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy has death? his certificate his director, page 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral di this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural
2 Accident Hospital or Attending work? 1 ☐ Yes 2 ☐ No 5 Pending М Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only on 3 🔲 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu e and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 7-30-12 DQ071287 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #4105, Baltimore, hosles 70 N. 6 31. Date filed (Month, Day, Yea State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Kathleen Horvath 19, 11:56 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 5935 Abrianna Way #N Elkridge Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Hours (Month, Day, Year) 496-54-1443 63 **Director** 1 □ M 2 🛣 F Nov 8, 1948 New York Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 Yes 2 No Howard Elkridge 10e. Street and Number 10f. Zip Code Citizen of What Country? ò must be Funeral USA 21075 5935 Abrianna Way #N items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify white "natural". Completed 3 Widowed 4 Divorced er than "natur, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) education teacher 12 d other event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ည Hilda Vertsch Joseph Horvath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 1764 Winsord Ct; Hanover, MD 21076 19a. Informant's Name/Relationship (Type, Print) Essam Ibrahin - husband Health tem 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or hear failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician Medical Due to (or as a consequence of) Examiner Sequentially list conditions. cause. Enter Underlying Exami Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Day Pregnant at time of death the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed after death.

Director: After this certificate | 1 🗆 Yes 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 2 D0055810 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dorsey Hall Dr, Elliott City Suite 201 Ras-Mahadevia 4801 31. Date filed (Month, Day, Year . Registrar's Signaty State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 1:33 P Dingju F. Hsueh July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 1av 16,1916 1 🗆 M 2 🗶 F Days Hours Min. **Director** China May 045-70-2540 96 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Virginia Fairfax Great Falls ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Taiwan 22066 1208 Colvin Meadows Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 K No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Asian Specify 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 than and Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is 22066 1208 Colvin Meadows Lane, Great Falls, Va. Danny Hsueh/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State National Memorial Pk. 7/30/2012 Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Money & King Funeral Home,
171 W. Maple Ave., Vienna. Gary R. Downer Inc. Virginia CCO 508 22180-9998 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) a. Fever Medical Due to (or as a consequence of): Examiner Foot Cellulitis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami sician and burial-trans Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA ၉ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending n 24 hours after death.

e Funeral Director: After the function of the functin 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопрете (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Pwithin 24 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title certi 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

Division of Vital

7600 Carroll Ave.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO

Ameet Parikh,

AUG 0 1

31. Date filed (Month, Day, Year)

70244

Takoma Park, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Olethia 3:03 M 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A 1 trucere varitan Hospite 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) (Month, Day Year) Sep 19, 1957 1 🗆 M 2 💆 F Hours Min. Director 213-72-5713 54 MD Usual Residence of Decedent 28a-f shov 10b. Count 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No **Baltimore Baltimore City** 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a 21218 U.S.A. 1554 Sheffield Road 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married ρ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates "natural", Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George E. Hooks Nellie M. Cornish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1554 Sheffield Road Baltimore, MD 21218 Nicole Bank Ayala Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Western Cemetery 20c. Location - City or Town, State Page 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Aug 01, 2012 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition redione Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of) burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Unknown P.O. 1 signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 esistant Staphylococrus Records, No 3 Probably 4 Unknown 1 Yes page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cheo bronch, tis the Hospital or Attending Physician: The law ithin 24 hours after death.

Hin 24 hours after death.

He Funral Director. After this certificate has the fer or the form of the autopsy perform Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 Appatient 2 ER/Outpatient 3 DOA 27. Manner of De th 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work?
1 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number NPT: 185 RP 5000 29d. Date signed (Month, Day, Year) : 185/655 5000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D liasun

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day,

AUG 0 1 2012

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Certific	ate of	Death			R	Reg. No.	<u>_</u> _ \	U I	2 2 4 4 0
Physici		1 Month Day Ye												3. Time of Death 1901 hrs
/ledical Exami	ner	Donna Jean Ha  4a. Facility Name (if not institution					h City Town	July 24, 2012  City, Town, or Location of Death 4c. Cou						19011113
		1111 Robin Hill Ct	iii, givo stroc	t and namber)			Bel Air	OI EGGGIGH	Of Boutif		- 1	Harford	Dodai	
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last birt	hday)	If Under 1 \	ear If Und	er 24Hrs.	8. Date of Bi	irth (MM/	/DD/YYYY)	9. Birth	place (State or
Director		183-54-8928	1 M	2X F	51	Yrs.	Months E	ays Hour	s Min.	Sep.	30,	1960	Foreigr	California
		Usual Residence of Decedent												
W any		10a. State 10b. County	-	1	IOc. City, Town		on							10d. Inside City Limits
Maryland 28a-f show	ē	Maryland Harfo	rd ———		Bel Ai	r								1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e. Street and Number					10f. Zip Cod					izen of Wha	it Count	try?
th the 23a o		1111 Robin H				10.111	21015 USA s Decedent of Hispanic Origin? (Specify Yes or No- 14. Ra						A ' -	and to Man Black
ath wi	Funeral	11. Marital Status 1 Never Married 2 M	arried .	Was Decedent E			s Decedent of es, specify Cul				o-	White,		an Indian, Black,
ter de		3 Widowed 4 X Div	orced If Yes,		No	1	Yes 2 X	No specify	:		ı	Specify:	TAT!	nite
5-0036 led within 72 hours afte thygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Spe	or Dat	les:		Decedent	's Usual Occu	pation (Give	kind of wo		16b. l	Kind of Busi		
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036 within 72 ene. er than Medical				4	R	egist	tered N				_	ealth	Cai	re
Hygin doth		17. Father's Name (First, Middle	,						,	First, Middle,		•		
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Baltimo permit. Page Department of Important: injury or oth	H	4 Donation 5 Other Specify: ROSE HILL SVCS, LLC //30/12 Be 21/Signature of 5 meral Service ricensee 22. Name and Address of Facility McComas Fune												
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Physician	ヿ	23a. Part I. Enter the disease, or failure. List only one cause	compleation	ns that caused th	ne death. Do no	t enter th	e mode of dyi	ng, such as o	cardiac or r	espiratory an	rest, sho	ock, or hear	t	Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease		pertensi	ive Car	diova	ascular	Dise	ase					Death
		or condition resulting in death)	Due to	(or as a consec	quence of):									
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760, icate be ex physician the burial	S S	IF FEMALE:	23c	. If yes, outcome	e of pregnancy						230	d. Date of de	elivery	
		23b. Was decedent pregnant in the past 12 months?	1 1 1	Live birth	2	Feta	ai death	3 Ectopi	c pregnanc	Э		Month	Da	ay Year
Box 687  ne death certific  the attending is	Physician/	1 Yes 2 No 9 ✔ Uni	nown 4 5	Pregnant at ti	me or death 5	Oth	er (Specify)							
that the d	E	Part II. Other significant condit			but not resulting	in the ur	nderlying caus	e given in Pa	art I.	23e. Did t	obacco	use contribu	ute to th	ne cause of death?
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Records,  The law require fificate has been sire page 2 should be	Completed									autor perfo	rmed?	de	ath?	mpletion of cause of
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the finneral director, page 2 should be detached for use as		25. Was case referred to medica			-	_	26.Pla	ace of Death	(Check on	hammed.	ZIN	1	<b>y</b> Yes	2 No
Division of Vital talor Attending Physician: Its after death.  **I Director: After this certical in by the finneral director.	o Be	examiner? 1  Yes 2 No	Hospita	l: 1 Inpatien	2 ER/0	utpatient	3 DOA	Other <sub>4</sub>	Nursing	Home 5	Reside	ence 6	Other:	Scene
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ivis or An after of Direc	흷	3 Suicide 6 Coul	d not be	8e. Place of Inju	ry - At home, fa	rm, street	t, factory, offic	e building, e	tc. 2	8f. Location ( or Town, \$		ind Number	or Rura	al Route Number, City
Division To the Hospital or Attency within 24 hours after death To the Funeral Director:	Š	4 Homicide 29a. Certifying Pl	mined (	Specify)						·				
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0000	-	30. Name and address of person	who comple	ted cause of de	ath (Item 23a)						1		-	
3		Pamela E. Southall, M		istant Medic	, ,	r 900	W. Baltim	ore Street	t, Baltim	ore, MD 2	1223			ļ
	ate	31. Date filed (Month, Day, Year)	/	32. Registrar's	Signature	-								
Regist	rar	100 0 T 5015	Second .	B. 1	harris							-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 27 6:05 P. M Roseann Marie Hanash Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist @ GBMC Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 217-66-3427 Director 1 □ M 2 🔀 F Aug. 24, 1956 55 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner man be once. 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1224 Chipper Drive 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Food Sales Sales Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frederick Maurice Gebhart Patricia Irma Clutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leila Walker / Daughter 4903 Forge Haven Drive, Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 D Cremation 3 Removal from State Rose Hill Svcs. LLC Bel Air, Maryland 8/1/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Sight re of funeral Since Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 that u the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications Approximate Interval Between shock, or heart failure. List only one cause of Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural (Month, Day 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. fedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ 6 ly one artifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 851700C of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24438 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 July 27, Physician/ Everett Lee Handy Jr. 3:09 A. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Social Security Number 7. Age (In yrs. last birthday) Days Hours Min (Month, Day, Year) 212-30-5941 Director 1 **X** M 2 □ F 80 Aug. 2, 1931 North Carolina Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 Tes 2 No 28a-f Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be 23a Funeral 1400 Hanson Road 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 010 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: item 27 is marked other than "natural", other traumatic event, the Medical Exa White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Engine Part Supplies Branch Store Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Everette Lee Handy Sr. Pearl Margaret Gaultney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is, any injury or other traunonce. Margy Handy / Wife 1400 Hanson Road, Edgewood, Maryland 21040 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Trinity Lutheran Cem. 7/31/2012 Joppa, Maryland 4 ☐ Donation 5 ☐ Other (Specify) aturn of Furferal Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 14mh 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or co. plant institut caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colon Cancer month disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D66912 7/27/12

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year) **AUG 0 1** 2012

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MOOD 136

HANDY.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) apeake Drive BelAir MD 21014
Dr. Venkata Parsa 5000 perchosapeake Drive BelAir MD

amend #4b, per phy, g930 8-1-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Elizabeth Anne Huza 2 Date of Death 3. Time of Death Physician/ Month Jul 2012 05:15 AM HUZA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia HOWARD HOW ARD COUNT GOLUMBIA GENERA HOSPITA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth **Funeral** (Month, Day Year) Feb.4, 1953 Days 1 M 2 X Canada 237-65-8852 59 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Canada 7251 Riding Hood Circle 21045 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paul Girouard Dorothy Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Huza - Husband Riding Hood Circle, Columbia, Maryland 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 

Burial 12 

Cremation 3 

Removal from State Atlantic Crematory Inc. 07/29/12 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP Funeral Servic Licens 21. Sign | ebeca MO1283 7250 Washington Blvd., Elkridge, Maryland 21075 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

A MONNS Immediate Cause (Final Phinician/ CANCER METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Dav Year Pregnant at time of death 1 ☐ Yes 2 ¶ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Io the mosphers. To the funeral breath.

To the Funeral Director. After this certificate has I can the funeral director, page 2 that the funeral director, page 2 that the funeral director, page 2 that the funeral director, page 2 that the funeral director, page 2 that the funeral director, page 2 that the funeral director, page 2 that the funeral director, page 2 that the funeral director, page 2 that the funeral director, page 2 that the funeral director, page 2 that the funeral director has the funeral director and the funeral director has the funeral director and the funeral director has the funeral director and the funeral director an autopsy death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 🗷 No Other: 1 Propatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural Accident injury 5 Pending Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) D50404 Ju 27, 2012 PHYSICHOU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA 21044 PATEL 10632 #111 PATRIXENT YTHE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

AUG 01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Augustine Hutchinson **Physician** Juck 28 11:40 A M 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Randallstown Future care old court If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 3 € F Yrs Director 212-42-5198 10 23 MD Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Owings Mills Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 U.S.A. 4534 Donatello Square Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Black Completed by 3 Widowed 4 Divorced 'natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) University of MD al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dental School Dental Assistant 12th grade 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Menta is marked Augustine E. Snowden Walter H. Jeffries 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4534 Donatello Square, Owings Mills, Md Kelly Henson-Niece Health em 27 i other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) New Cathedral B/3/2012 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Jarch 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Systolic Congestive heart failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner chronic Kidney Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by t 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions of ntributing to death but not resulting in the underlying cause given in Part I. Completed by upertension Malignant 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page perform certificate 1□ Yes 2XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4MNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? After t Certification: 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. rerai Director: / 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed P.O. or Vital Records,

Baltimore, Maryland 21215-0036

Division Hospital or Attending hin 24 hours a

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

ijun Zhon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

POBox 2613. salisbury, MD 21802

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month HOUSER FRANKLYN 355PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 8. Date of Birth (Month, Day, Year) 1,1955 Carroll Hospital Center Westminster 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 57 213-66-6329 1 🔀 M 2 □ F **Director** Maryland Usual Residence of Deced 28a-f show items 23a or 28a-f sho ner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director PA Littlestown Adams 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 17340 USA 455 Basehoar Roth Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò by Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates "natural", Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Systems Programmer Be 18. Mother's Name (First, Middle, Maiden Surname)
Lucille R. Nagel 17. Father's Name (First, Middle, Last) မ John C. Houser other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 455 Basehoar Roth Road Littlestown, PA 17340 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Mildred E. Houser - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) Atlantic Crematory 7/30/12 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc 4107 Wilkens Avenue Baltimore, MD 21229 any 12-C 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ emsta disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** quentially lifet conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Division of Vital Records, P.O. Box in the past 12 months? Month Day Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1100 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 4 hours after death. uneral Director: Aftely filled in by the fur 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie within 24 hor To the Fune completely f (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat 29d. Date signed (Month, Day, Year) 139502 M1 d address of person who completed cause of death (Item 23a) (Type, Print) 447, EAST MAIN ST WESTHINSTER MODINT 31. Date filed (Month, Day, State

HMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 Pestate of Mary and 1/2012 The partment of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 5: 00 A M Physician/ Heyward Samuel Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (if not institution, give street and number) Examiner 2449 Shirley Avenue 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Aug 24, 1946 **Funeral** Days Min. Auguntry 4 Hours. Months 247-80-3732 65 1 🖾 M 2 🗆 F Director Yrs. South Carolina Usual Residence of Dec 10d. Inside City Limits 28e-f show 10c. City, Town or Location 10b. County 2 should be filed within 72 hours after death with the Maryland that and Mertel Hygiene. 27 is merked other then "natural", or items 23e or 28e-f show the morked other than "natural". N/A Baltimore MD 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? ۵ 10e. Street and Number 21216 USA 2115 Mt. Holly Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Black Specify: 1 Never Married 2X Married δ 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Carpet Layer Elementary/Secondary (0-12) 10th College (1-4 or 5+)
N/A Self Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna B. Green Joseph Heyward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Mt. Holly St. Balto., MD 21216 <sup>19a.</sup> Informant's Name/Relationship *(Type, Print)* Chiquita Winchester/Friend mit. Pege 1 end 2 st pertment of Health e portent: If item 27 i y injury or other tre 20c. Location - City or Town, State Charleston, S.C 20b. Place of Disposition (Name of Name) Place Cem 20a. Method of Disposition 8/8<sup>Date</sup> 2 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/s 2700 Edmondson Ave. Balto., MD 21223 Signature of Juneral Service Licensee 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Luna Canver Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien end s the burlal-transit Hospitel or Attending Physicien; The law requires that the death certificate be executed Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 ettending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Month Year in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 of Other (Specify) 2 1 No P 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of injury 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 5 Pending 1 Matural 1 Yes 2 No Investigation within 24 hours after death

To the Funerel Director: A

completely filled in by the Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier nsllyapathemo 7/28/12 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 2805 SMIM AV 5203 NSRAJAPOKSEMD 2. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Jackson 10:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Northwest Hospital Randallstown Battimore Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 220.80.297 (Month, Day, Director 1 X M 2 | F 1960 10 29 ge 1 and 2 should be filed within 72 hours after death with the May/and nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Owings Mills 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 9 Richman USA Road, Apt. 2117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12+h grade College (1-4 or 5+) Maintenance Vestministe permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumasticant. Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Kobert Elaine Atkins 19a. Informant's Name/Relationship (Type, Print) (WIFF) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Richmar Road, Apt. Hollida DWINGS MILLS, MD 2117 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Woodlawn, MD 106 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility Valighn C. Greene Funeral Savies Approximate Interval Between Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Was a. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 🗌 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Tother (Specify) 2 1 No Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

MS Neyup Wind MD 29c. License number 29d. Date signed (Month, Day, Year) DO057465 7/28/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS Ray aparese MD Baltimore MD 21209 2835 Smin N 31. Date filed (Month, I 32. Registrar's Signature State Registrar

			Please Type or Prin AMEND, ITE State of Ma 2/25/2013	t in Black I	ndelible Inlead Land Hock Landment of F	k. Ensure All Copie 1, e f 16 a 19 a 7 lealth and Mental H	es Are Legible 0a-c, 22perF	H,G936
			Registrar	,ws Ce	rtificate of L	Death	Reg. No.	6 64444
	Physicia Medi		1. Decedent's Name (First, Middle, Last)  FRANK DEE JONE			2. Date of D Month	Day Year	3. Time of Death
العيوا	Examir	ner	4a. Facility Name (if not institution, give street and number) Prince George's Hospita	ıl Center		Location of Death	4c. County of Dea	
10	Funeral Director	Г	5. Social Security Number 6. Sex 7. Age (	(In yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of B Hours Min. (Month, L	irth 9. Bir	thplace (State or Foreign ountry)
3	d ow t		Usual Residence of Decedent		<u>                                     </u>	June 9	, 1953 Nort	h Carolina
	faryland 8a-f sh tified a	ectol	Washington	10c. City, Town or Lo				10d. Inside City Limits 1  ✓ Yes 2  ✓ No
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Helen Burro	Washingto Oughs Ave	10f. Zip Code 2001	0019	10g. Citizen of What Co	ountry?
9	ter death , or items aminer m	by Fun	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Every Armed Forces 2 Never Married 2 Married	0	If Yes, specify Cubar	spanic Origin? (Specify Yes or No n, Mexican, Puerto Rican, etc.)	Black, Whit	e, etc.
003	rurs af tural" al Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2x No		Specify: Bla	ıck
21215-0036	hin 72 ho ne. than "na ne Medic	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	(Give life, L	OO NOT use retired)	uring most of working	16b. Kind of Business	
	filed within al Hygiene. d other thai vent, the N	Be C	17. Father's Name (First, Middle, Last)	For	klift Open	18. Mother's Name (First, Middle	1	g company
Maryland	should be file and Mental H is marked or raumatic eve	To	Frank L. Jones Sr.			Vennie Karne		
Mar	2 should th and Me 27 is mar traumati		19a. Informant's Name/Relationship (Type, Print)  Brenda Jones	19b. Maili	ng Address (Street a Farragut	nd Number or Rural Route Numb St; Washingto	per, City or Town, State, Zi	p Code)
	1 and 2 s if Health item 27 i		Brenda F. Jones/Sister  20a. Method of Disposition	20b. Place of Dispo	osition (Name of	treet, Temple	Hills, MD 20 20c. Location - City or	748 Town, State
mo	nit. Page lartment o ortant: If injury or e.		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ Removal from State 4 ☐ Donation 5 <b>X</b> Other (Specify) <b>1n - State</b>		matory or other place	8/8/2012	Beltsville.	MD
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Sign ture of the Licensee Ronald S. Vale Direct	tor A	2. Name and Addres  15 Ein Roys  15 In Con	ster Funeral. Ho	tomy Board Pt. 7821 14th	Street, NW
	Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused it shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury	the death. Do not ent	er the mode of dying	, such as cardiac or respiratory ε	irrest,	Approximate Interval Between Onset and Death
Box 68760	Attending Physician: The law requires that the death certificate be executed tre death.  **redeath.** **ectors** After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Exa	that initiated events resulting in death) Last C. Due to (or as a condition of the conditio	pregnancy	Ectopic pregnancy	,	23d. Date of de Month	livery Day Year
P.O.	that the led by detac	by Ph	Part II. Other significant conditions contributing to death but	not resulting in the I	underlying cause give	en in Part I. 23e. Did	tobacco use contribute to	the cause of death?
ds,	quires en sigr ould be	ed b	_alcoholic liver dise	eace		1 🗆	lYes 2□No 3□P	robably 4 Unknown
Division of Vital Records,	The law rec ate has bee page 2 sho	Completed	Seizure disorder			per	opsy prior to death?	topsy findings available completion of cause of
Ea	ician: The certificate rector, pag		25. Was case referred to medical examiner?			ce of Death (Check only one)	2 2 110	
ΨŽ	ding Physician:  After this certific funeral director,	욘	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 27. Manner Death 28a. Date of injury	2 ER/Outpatie		4 ☐ Nursing Home 5 ☐ Res		rify)
o u	nding th. : After e fune	cate	1 Natural 5 Pending 2 Accident Investigation (Month, Day, V		work?		how injury occurred	
Divisio	Hospital or Attending I 24 hours after death. Funeral Director: After etely filled in by the funer	Certificate:	3 Suicide 6 Could not be	- At home, farm, str Spec <i>ify)</i>		28f. Location	(Street and Number or Ru wn, State)	ral Route Number,
_	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	Medical	29a. Certifier 1 Certifying Physician: To the best of my (Check only one) 3 Certifying Nurse Practitioner: To the basis of examiner:	mination and/or inves	tigation, in my opinior	i, death occurred at the time, date	and place, and due to the	cause(s) and manner stated.
	vithi To th	-	29b. Signature and title of certifier    3 land	L D0	29c. License		29d. Date signed (Monte) 7 / 2 3	
			30. Name and address of person who completed cause deal A 131inn Black 3007	h (Item 73a) (Type, F		herekly,	mp 201	785
	Stat Registra		31. Date filed (Month, Day, Year)	Signature	Red		0.0_/	

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AMEND TTEM#5perFH, g953.7/17/2014, WS
State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 29 20T2 6:10p.M Jones Howard Royal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death TOWSON 4c. County of Death Baltimore **Examiner** Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** <del>213</del>-64-5388 Hours Days Min Country) Director 1 X M 2 □ F 57 10 26 54 MD ed other than "natural", or items 23a or 28a-f shover the Medical Examiner must be notified at 10a, State within 72 hours after death with the Maryland 10h Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Baltimore Randallstown MD 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? Funeral 21133 U.S.A. 3700 East Man Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. 1 X Never Married 2 Married 2 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12th grade Steel Worker Bethlehem Steel Corp. permit, Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: if Item 27 is arried other any injury or other traur atto event, if 2002. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ulice Jones Virginia Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7608 Ashton Valley Way, Catonsville, Md 21228 Renard M. Jones-Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park 8/3/2012 King Woodlawn, Md 21. Signature of Puneral Service Licensee 22. Name and Address of Facility March F/H West CL 4300 <u>Wabash Ave,</u> Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 11/61 disease or condition 100 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year ed by the a ☐ Yes 2 ☐ No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 3 Probably 4 Unknown 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 Yes 2 No Yes 盎 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bigcirc$  Other (Specify) Hospital: 1 Yes 2 No |요 1 Inpatient 2 I ER/Outpatient 3 I DOA Director: After this ad in by the funeral d 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation the Funeral Directory filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 3 🗌 of ly one trifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated d title of certifie 29b. Sid D007158-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PWWA Shaheen, 670(N. Challes St. # 4(05, Baltimore, MD 21204 State 32. Registrar Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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2	0	Parameter &	2	2	1	1	1	6

	1- For State Certificate of Death Reg. No.										
Physician/	Decedent's Name (First, Middle,Last)	2.	Date of Death  Month Day Year  4504								
Medical Examiner			July 21, 2012 1534 nrs								
	4a. Facility Name (if not institution, give street and number)  Baltimore Washington Medical Center	4b. City, Town, or Location of Death Glen Burnie	4c. County of Death Anne Arundel								
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bird		8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign								
Director	- Infant I XM 2 = F	Yrs.   Months Days Hours Min.	July 13, 2012 Country Maryland								
	Usual Residence of Decedent										
w any	10a. State   10b. County   10c. City, Town   Maryland   Howard   Hai		10d. Inside City Limits 1 ☐ Yes 2 📉 No								
aryland Sa-f show at once,		nover									
the Maryland a nr 28a-f sh tified at one Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?								
23a n	7775 Rotherham Drive	21076	USA								
r death with or items 23 must be no	1 X Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ric									
	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 y No specify:	Specify: Black								
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5-0036 ed within 72 hours at siggiene. other than "natural the Medical Examin Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life, DO NOT use retired	i) ~								
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21215-0036 Suld be filed within 7 Mental Hygiene. marked other than ic event, the Medical TO Be Compile			ral Route Number, City or Town, State, Zip Code)								
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ore, ME s 1 and 2 s of Health a of free 27	20a. Method of Disposition 20b. Place of	of Disposition (Name of cemetery,	Hanover, Maryland 21076 Date   20c. Location - City or Town, State								
Baltimore, permit. Pages I ar Department of He Important: If it injury or ather its	Tellioval Iloll State	ory or other place)	100 /10								
	4 Donation 5 Other Specify: Atlan  21. \$ignatur of Funeral Service Usins										
Balt permit Depart Impor	1 1 1 h . a 1 P V G	y L. Kaufman F.H. @ MMP d Elkridge, Marvland 21075									
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do no		espiratory arrest, shock, or heart Approximate Interval								
/Medical	failura Listonly of elause on each line. Immediate Cause (Final disease a <b>Concenital Cardia</b>	c Anomalies	Between Onset and Death								
Examiner	or condition resulting in death)  Due to (or as a consequence of):	C THIOMETTED									
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Box 68 death certif the attending of for use as	past 12 months?  4 Pregnant at time of death										
b. Box 68 the death certify the death certify by the attending ched for use as Physician	1 Yes 2 No 9 Unknown 9 Unknown										
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Records, I The law requires ficate has been sig , page 2 should be Completed			1 ✓ Yes 2 No 1 ✓ Yes 2 No								
tal Rec	25. Was case referred to medical examiner? [Hospital: 1 ] Inpution 2 A EU/O	26.Place of Death (Check only									
f Vi Physical this ral dir	1 ✓ Yes 2 No		Home 5 Residence 6 Other:								
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Sior Attend r death ector: by the	2 Accident Investigation 28e Place of Injury - At home fa		of, Location (Street and Number or Rural Route Number, City								
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should be dical Certification: To Be Completed	3 Suicide 6 Could not be determined (Specify)	Tin, street, factory, office building, etc.	or Town, State)								
0-=> -	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and du	e to the cause(s) and manner as stated								
To the Hos within 24 h To the Fue completely	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	rvestigation, in my opinion, death occurred at the	ne time, date and place, and due to the cause(s)								
F S P S	29b. Signature and title of certifier	29c, License number	29d. Date signed (Month, Day, Year)								
	Alle Grand The	O.C.M.E.	July 22, 2012								
_	30. Name and address of person who completed cause of death (Item 23a)	000 Mt Dallia	MD 04000								
		900 W. Baltimore Street, Baltimore,	, MD 21223								
State Registrar	31. Date filed (Month, Day, Year)  AUG 0 1 2012	have									
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	Physicia Medic		1. Decedent's Name (First, Middle, La Michae	1 Ku	uriger					2. Date of De Month JU(V)	27	ay 20	Year	3. Time of Death
- No.	Examir	ner	4a. Facility Name (if not institution, give		7)		4b. City, Town, o		of Death		4	c. County		
-	Funeral		1410 Perrywood D 5. Social Security Number 6. S		Age (In yrs. la	st birthday)	Aberde	If Under	24 Hrs.	8. Date of Bir	th	Harf		lace (State or Foreign
	Director		192-52-2129	<b>™</b> 2 □ F	52	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)		Count	ry)
	d d	_	Usual Residence of Decedent  10a. State 10b. County			, Town or Lo	ation			Jan. 1	υ, Ξ	1960		nsylvania Od. Inside City Limits
	arylan a-fsh	Sct	Maryland Harford	i		erdeen							- ['	1 Yes 2 No
	or 28	ä	10e. Street and Number				10f. Zip Code				10g. C	itizen of W	hat Coun	
	s 23e	Funeral Director	1410 Perrywood	Drive			210	01			τ	JSA		
	death r item		11. Marital Status	12. Was Deceder Armed Forces	s?		Vas Decedent of H f Yes, specify Cuba	lispanic Ori an, Mexica	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)			- America	an Indian,
21215-0036	el", o	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Dates	∐ No	1	☐ Yes 2 🛣 No	Specify	:			Specify:		nite
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121	hin 72 ne. <b>than</b> "	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4 c	or 5+)	life. De	kind of work done O NOT use retired) & Driver		t of Worki	ng		pplia		
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<u>a</u>	be file ental rked c	힏	George Gilmore M	Kuriger						Rose Go		,		
Maryland	hould and M is mai		19a. Informant's Name/Relationship (1	Type, Print)		19b. Mailin	ng Address (Street	and Numb	er or Rura	l Route Numbe	er, City o	r Town, St	ate, Zip C	code)
Σ	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28a-f show with injury or other traumette event, the Medical Economer must be notified at once.		Josette M. Kurige	er / Wife		1410	Perrywo	od Dr	ive,	Aberde	en,	Mary	land	21001
Baltimore,	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	ate C6	emetery, cren	sition (Name of natory or other place			Date		Location -	-	
弄	it. Partmer		4 Donation 5 Other (Speci	**	Dar		n Cemete  . Name and Addre			-2012				Maryland
Ba	permi Depar Impor eny ir		Must Market	moul			. 317 Coke							
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	plications that caus	sed the death	. Do not ente	er the mode of dyir	ng, such as	cardiac o	r respiratory a	rest,	•	Ī	Approximate
,	Physician/		Immediate Cause (Final disease or condition	ENCh.	Starl	Liver	Disease							Interval Between Onset and Death
- d	Medical Examiner		resulting in death)	Due to (or a	as a consequ	ence of):								
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or a	as a conseque	ence of):							-	
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
	be executed sician and burial-transit	al E)	resulting in death) Last	Due to (or a	as a conseque	ence of):								
260	eath certificete b attending physic 3 for use as the b	edic		d										
Box 68760	certifi inding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnan					23d. Date	of delive	ry
Bô	death he atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnan	t at time of de		Other (specify)	Ly				Mon	th	Day Year
P.O.	hat the dea ed by the a detached i		Part II. Other significant conditions	contributing to deat	h but not resu	ulting in the u	nderlying cause gi	ven in Part	1.	23e. Did t	obacco	use contril	oute to th	e cause of death?
S, F	uires that n signed uld be de	Completed by								1 🗆	Yes 2	No :	3 🗆 Prob	ably 4 Unknown
Š	ıw require is been si 2 should	plet								24a. Was		24b. W	ere autop	sy findings available npletion of cause of
Rec	The law ate has page 2	E G								auto perfe	ormed?	d	eath?	
<u>ra</u>	icien: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				lace of Dea	th (Check	only one)				
Ž	Physicie this cert	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inp	atient 2 🗆 I	ER/Outpatier 28b. Time of		4 ⊔ N		me 5 Resi				
o LC	nding F ath. After e funer	icate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, I	Day, Year)	injury	work	yai ∢? Yes 2 □	- 1	28d. Describe I	now inju	ry occurred	3	
Division of Vital Records,	r Atter ter deg rector	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	pe 28e. Place of I	Injury - At hor etc. (Specify)	me, farm, stre	eet, factory, office			28f. Location (			or Rural	Route Number,
وَ	To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	sal C	29a. Certifier 1 Certifying Phy					- 4 - 1						
	e Hos 724 h e Fun eletely	Medical		vsician: To the best niner: On the basis o rse Practitioner: To	f examination	and/or invest	igation, in my opini	on, death o	ccurred at	the time, date a	and place	e, and due	to the cau	se(s) and manner stated.
	Vithii Cong	_	29b. Signature and title of certifier			,	20c Licene	o numbor			204 D	-A- alad	7.44L F	Nav. 1/2-2
	1/2		► MSRajapin				Do	057	465			7/7	71	12
_	24.21		30. Name and address of person who A SAG LYAN ZEMU 31. Date filed Wagth Day Yand 12	completed cause o	f death (Item	23a) (Type, F	S70.	3	Balt	more	M	07	170	9
	Sta Registr		31. Date filed Weath Day Year 2012	32. Regis	strar's signatu	Barke	1							

DHMH 17 Rev 06-2011

			Please	State of	rint in nd #20 Marylan	Black I a,per d/Dep	ndelible Inl fh, g930 artment of F	c. Ensure 3–9–12 lealth and	e All Copie sm d Mental Hy	es Are L /giene	egible.	- 1 1 1 0	
		4	For State Registrar		, , , , , , , , , , , , , , , , , , ,		rtificate of L			Reg. No.	2012	24448	
	Physicia Medic		1. Decedent's Name (First, Middle, La Wilbur	,	fers		Keeton	Jr.	2. Date of Do Month	Day	Year 201 2	3. Time of Death	
	Examin	er		e street and numbe			4b. City, Town, or BALTIMO	RE LIT	У	4c. Co	unty of Death		
	Funeral Director		5. Social Security Number  214-58-7316  Usual Residence of Decedent	Sex 7. 1 □ <b>X</b> M 2 □ F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		in. (Month, D	irth Pay, Year) 30 51	Cour	place (State or Foreign ntry) MD	
	show dat	ţō	10a. State 10b. County			y, Town or Lo		J				10d. Inside City Limits	
	e Mary r 28a-f notifie	Director	MD NA  10e. Street and Number			Balt	imore			10 00:	F144 - 1 O -	1X Yes 2 No	
	with th	eral [	926 Elton Ave				10f. Zip Code	1224		_	of What Cou	-	
9036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 ☐ Never Mamied 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date:	s? <b>X</b> No		Was Decedent of H If Yes, specify Cuba  1 ☐ Yes ② No	n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Black		
15-0	72 hou "natu ledical	Completed	15. Decedent's (Specify only highest g			(Give	dent's Usual Occup kind of work done of OO NOT use retired)		vorking	16b. Kind Dept	of Business/Ir	dustry General	
212	within giene. er thar t, the M		Elementary/Secondary (0-12) 12th grade	College (1-4 3yrs	or 5+)	1	curity	Office	er	Serv	ices		
and	be filed ental Hyg ked oth ic event	To Be	17. Father's Name (First, Middle, Last, Wilbur Jeffers		Sr.				Name (First, Middle H. Whit		name)		
Maryland 21215-0036	should h and M 7 is mar traumati	Ė	19a. Informant's Name/Relationship ( Denise Keeton-	Type, Print)		19b. Maili 926	ing Address (Street : Elton A	and Number or	Rural Route Numb	er. City or Toy	vn. State, Zip 21224	Code)	
Baltimore,	Page 1 and 2 nent of Healt int: If item 2 iry or other		20a. Method of Disposition  1 1 Surial 2 1 Cremation 3 1 4 Donation 5 D Other (Spec	ion - City or T									
Balti	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Thereil Service Lice	imore	, Md	21215							
	Physician/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final		line.	h. Do not en						Approximate Interval Between Onset and Death	
	Medical Examiner		disease or condition resulting in death)	Due to (or	as a conseq	uence of):				0			
		Jer	Sequentially list conditions, if any, leading to immediate	b. SEVER	as a consequ	PSIS uence of):				3			
0	s be executed sician and e burlal-transit	icał Examiner	cause Enter Inderhing Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):							
. Box 68760	Attending Physician: The law requires that the death certificate be executed archeal.  To death.  Setor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burlal-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outco 1 ☐ Live Bir 4 ☐ Pregna 9 ☐ Unknov	th 2 Detaint at time of	al death 3	☐ Ectopic pregnand ☐ Other (specify)	ey .		230	d. Date of deli	very Day Year	
s, P.O	ires that the signed by the signed by the details in the details in the signed by the		Part II. Other significant conditions CONCESTIVE HEART	-		-				100		the cause of death?	
Division of Vital Records, P.O.	≥ ∞ ⊲	Completed by	MY PETENSION, DYSU	PIDEMIA,	OSTEC	ARTH R	ling, Gol	٠٦٠	per	s an 2 opsy formed?		opsy findings available ompletion of cause of	
Ital	ician: T	Be	25. Was case referred to medical examiner?	Hospital:			Oth	Or:	Check only one)				
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<u>o</u>	tendin death. tor: Aft the fur	Certificate:	↑ Natural 5 ☐ Pending 2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not	on be	Day, Year)	injury		Yes 2 No					
Divis	al or At s after o		4 ☐ Homicide determine	28e. Place of	Injury - At he etc. (Specif)		reet, factory, office			(Street and N own, State)	umber or Rura	al Route Number,	
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 D Medical Example (Check 2 December	niner: On the basis	of examinatio	n and/or inve	occurred at the time stigation, in my opinion, death occurred at	on, death occur	red at the time, date	and place, an	d due to the ca	ause(s) and manner stated.	
	Vith vith com		29b. Signature and title of certifier  Shadhark	Creery, M	BBS, 1	PG4. 2	29c. Licens	e number			igned (Month, 4/201		
)			30. Name and address of person who SHASHANK GARG, SING	HOSPITAL	of BAI	MIMORE	, 2401 W 8£	LUEDERE	. AUR , BA	LAMORE	, MO-21	215	
	Sta Registra		31. Date filed (Month, Day, Year)  AUG 0 1 2012	Second 32. Reg	strar's Signa	ture							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8, per fh, g930 8-29-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 8:03 Joseph Jerome LiCausi Medical 4c. County of Death Prince George's 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regional Hospita Laure If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min 579-36-2828 **Director** 1 X M 2 - F 18 Washington, DC Oct. 81 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🏋 Yes 2 □ No 28a-1 Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò pe 23a USA 5483 Wooded Way 21044 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Master Electrician IBEW Local #26 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ and Mental Nunzio Jerome LiCausi Antoinette Ignacious LaScola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20171 2372 Rolling Fork Circle #401 Herndon, Jennifer JoAnne Barb/ Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 🗶 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/3/2012 Washington, DC Olivet Cemetery 22. Name and Address of Facility Fleck Funeral Home 21. Signature of Funeral Service Ligenses 7601 Sandy Spring Road Laurel, MD 20707 23. Part 1. Enter the discussion, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Anoxic Encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Cardiopulmonary Resuscitation Prolong Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 Yes 2 No Accident
Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month. Day, Year, 31 2012 July Hospital 30. Name and addess of person who completed cause of death (Item 23a) (Type, Print) Regional RA EE-LLACER DA MD Dusen Laure 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death ededent's Name (First, Middle, Last) Physician/ **HOWN** :30P M Medical **Examiner** 4b. City Town, or Location of Death 406 Jonas Moodlawn Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 1 M 2 F Months 100**Director** show 10a. State Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No imore 10g. Citizen of What Country? Funeral 6406 21207 death 11. Marital Status . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ₩Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during life. DO NON use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Nled vear Be 18. Mother's Name (First, Middle, Brown Isie 19a. Informant's Name/Relationship (Type, Print) Niece) · Jomenville 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sign ure of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

e Funeral Director: After this certificate has I leaved filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 Tes ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 ☐ Acciden 3 ☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 31 who completed cause of death (Item 23a) (Type, Print) Belvedere State Registrar

230pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TEM# I perphys, G930, 87972012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle Last) Leonard Lepus 2 Date of Death 3. Time of Death Physician/ Month 0205 AM 2017 Jul. Medical 4a. Facility Name (if not institution give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medica Mercy ente. Baltimore Social Security Number 7. Age (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Month, Day, 220-74-8335 Min 1 🗙 M 2 🗆 F Director Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d, Inside City Limits Director MD 1 Yes 2 No Harford 10e. Street and Number 10g. Citizen of What Country? 2/085 Funeral End Drive 45 Woods 3010 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Technician County Government is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ance. and Mental ည John Leo Lepus Elaine M. Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon D. Lepus / Wife 3010 Woods End Drive, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 7/30/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fune a Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or compleshock, or heart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. nterval Between Onset and Death Immediate Cause (Final Failure Liver Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a conseq ence of Headith To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affecteath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 🔣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baydarian Michae 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of P Physician/ /onth 12ctm MOORE-BEG Medical u 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Randallstown 4c. County of Death Baltimore Examiner Seasons Hospice Social Security Number 8. Date of Birth (Month, Day, Ye 11-4-1949) If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 217-52-6348 Country) Director 1 ₹ M 2 □ F MD 62 or than "naturel", or Items 23a or 28a-f sho 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits rector Baltimore 1 X Yes 2 No n/a ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4220 Norfolk Avenue 21216 USA 12. Was Decedent Ever in U.S. Armed Forces2, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced Specify: African-American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) State of Maryland Supervisor It. Page 1 and 2 should be filed with them of Health and Mental Hygien reant: If item 27 is marked other 1 njury or other traumatic event, in Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mattie McLauphlin William MooreJr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon E. Pigford/Daughter 2028 W. Westmoreland Street, Philadelphia, PA 19140 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Speoff) permit. Page Department o Important: If any injury or 8-4-2012 Woodlawn, MD 22. Name and Address of Facility While Funeral Hone P.A. of Baltimore Co. Signature of Funeral Service <u>9200 Liberty Rd., Randallstown, MD 21133</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or itijury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires thet the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 🗆 No 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 1 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 234) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar AUG O

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4a, per phy, g930 8-1-12 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 927 AM Month Tul 2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death BENHURST AVE Road BALTIMORE N/ASocial Security Number Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 1 M 2 X F Hours 10/03/1983 Director 216-19-1859 28 Yrs. Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6311 BENHURST ROAD 21209 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 X Never Married 2 Amarried 2 X No 72 hours after ☐ Yes Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Specify: Completed WHITE Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) STUDENT EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JUDAH MINKOVE JUDITH FRUCHTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau DR JUDAH MINKOVE / FATHER 6311 BENHURST ROAD, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHEVRA AHAVAS CHESED 07/29/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line tod Immediate Cause (Final Onset and Death Physician/ 14 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the 88 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Pregnant at time of death detached the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by sign be Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a, Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 Yes 2 No autops Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Í No မ 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accider injury 5 Pending 1 Yes 2 No 24 hours after death Funeral Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) wan my who completed cause of death (Item 23a) (Type, Print) 2113 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 1 2012 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funeral Director		5 - 00 0000		7. Age (In yrs. Ia	7	If Under 1 Year Months Days		fin. 8. Date of E	1 -	Teoreigi	hplace (State or		
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MD 2 d 2 shoul Ith and N n 27 is m	۲	19a. Informant's ame/Relationship  Joseph Parso	/	her	N			Rural Route Nu			Zip Code) 2/229		
		20a. Method of Disposition		20b. Pi	lace of Dispositi	on (Name of cem	netery,	Date	20c. Local	tion - City or T	own, State		
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Baltimo permit. Page Department Important: injury or ott		21. Signature of Euneral Service Lice	Donation 5 Other Specify: On Site Cremation Center 08 01 2012 Balting Signature of Euneral Service Licensee 22. Name and Address of Facility Jaughn C. Greene Pul										
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Box 687 e death certific the attending	hysiciar	1 Yes 2 No 9 Unknow		nt at time of deat	h	r (Specify)			1				
O. B. at the de 1 by the tached f	Δ.	Part II. Other significant conditions			sulting in the unc	derlying cause giv	ven in Part I.	23e. Did t	obacco use c	ontribute to th	e cause of death?		
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of Vi g Physi fter this	P.	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of	Injury 2	R/Outpatient 28b. Time of Inju			ing Home 5 28d. Describe		6 ✓ Other: S	Scene		
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Division of Vital Records, tall or Attending Physician: The law require and are death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 X Could no determine	t be 28e. Place	of Injury - At hom	ne, farm, street,	factory, office bui	ilding, etc.				Route Number, City		
Bospital 4 hours a Funcral ely filled		29a. Certifier	(0,000))		ng Lot	d at the time, date	and place, an				mount Ave.		
Division of Vital Records, P.O. Box 68 within 24 hours after death certificate by the Hospital or Attending Physician: The law requires that the death certificate 44 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Examine		examination and									
	ž	29b. Signature and title of certifier		2		29c. License				signed (Month	h, Day, Year)		
		( Yand fret	har III, M			0.C.M	.E.		July 29,	2012			
K	g J	30. Name and address of person who Pamela E. Southall, MD				V. Baltimore	Street, Balt	timore, MD 2	1223				
		31. Date filed (Month Day, Year)		strars Signature			, _ ====	-,					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Margaret Boneta Powell 9:00 PM July 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14 Skyline Drive Conowingo Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Davs Hours Country) Director 215-30-0840 1 M 2 TX F Maryland Yrs Oct. 20, 1933 78 Usual Residence of Deced r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinan must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21015 1300 Scottsdale Drive, Unit J 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2K No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Georgia Belle Mabes Orther Clarence Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Skyline Drive, Conowingo, Maryland 21918 Sandra L. Vervier / Daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 R Bel Air Memorial Gdn. 7/31/2012 Bel Air, Maryland Donation 5 Other (Specify) McComas Funeral Home, P.A. Si ture of Fun 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Nemic Pnysician/ ase or condition Medical resulting in death) Examiner 4 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Daugneer '. Other: 4 Nursing Home 5 Residence 6 Dother (Specify Residence Hospital: 1 ☐ Yes 2 ☐ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) ame and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

01

2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Pestate of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 28, Day 2012 Year 10:43 P.M Claire Irene Plummer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Forest Hill Senator Bob Hooper House If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth Funeral 7. Age (In vrs. last birthday) Days Hours Min (Month, Day, Year) 219-18-0675 Director 1 M 2 XF June 14, 1924 North Carolina Yrs 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d Inside City Limits 10a. State Director 1 Yes 2X No Volusia Orange City Florida 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 32763 115 North Lake Drive, Apt. 112B 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Zollie Mae Higgins Posev Lester Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Ridgeway Blvd., Deland, Florida 32724 Ed Plummer / Son timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Remova from State Bel Air, Maryland Rose Hill Svcs. LLC 7/31/2012 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. Si neture of Fund Service License 22. Name and Address of Facility Bai 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury Examine Due to (or as a consequence of) the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.Ö. Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ☐ Ectopic pregnancy detached for Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown cate has been signed by tage 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2X No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) ใญก 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Other (Si 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) DULAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 30 DEACON JEROME KENNETH PIVEC. SR. 2012 7:55pM Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 4a. Facility Name (if not institution, give street and number, Baltimore Greater Baltimore Medical Center Towson 5. Social Security Numbe 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 5/11/1941 Director 217-40-8822 1**X**□ M 2 □ F 71 MARYLAND Usual Residence of Deced show 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director be notified 28a-f 1 Yes 2X No BALTIMORE PARKVILLE MD 0 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral must 83 DENDRON COURT 21234 <u>USA</u> or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. þ 1 Never Married 2 X Married 2 XNo 1 ☐ Yes If Yes, Give 1 Yes 2 X No Specify. Specify: 3 🗆 Widowed 4 🗆 Divorced Completed WHITE Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) DEACON CLERGY 12TH GRADE Be Baltimore, Maryland Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JEROME F. PIVEC ELEANOR DOHERTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 SUE ANN PIVEC/WIFE 83 DENDRON COURT PARKVILLE. MD21234 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spegify) PARKWOOD CEMETERY 8/2/2012 BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21, Signaturé of Funeral Service Licensee MO1189 8521 LOCH RAVEN BLVD. TOWSON, MD 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line ASPIRATION Immediate Cause (Final PHEY MONIA Physician/ disease or condition resulting in death) DAY Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be after death. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? signed by the atter Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, this certificate has been single and director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No 9 Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 28c. Injury at after death. Director: After Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2012 JULY 3 1 053 430 BALTIMORE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET SU17 E 3808 6701 CHARLES NORTH MARYLAND 21204 ERED CHAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 1 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Parker hy llis wly 30 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death J/A Hospital Baltimore Hopkins 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Country) **Director** 1 - M 2 - F PR:115 1964 28a-f shov City, Town or Location iral", or items 23a or 28a-f shore Examiner must be notified at within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 ☐ No 4MORE 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 1241 Good Will Tr Be 17. Father's Name (First Middle, Last) ပ BRKFR injury or other traumatic KUCA. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V. permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau SALIDO Method of Disposition 20b. Place of Disposition (Name of Location - Citro or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Ansdewne, MARGIANO 4 ☐ Donation 5 ☐ Other (Specify) Lion ure of Funeral Service Licens 22. Name and Address of Facility

NANCY M. WALLACE

Frankling Sen 3405 W. Franklin the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a varialure. List only one cause on each line. Enter Approximate Interval Retween Immediate Gause (Final Onset and Death Physician/ Sersis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? detached for Day Year Pregnant at time of death 2 🗆 No the 9 Unknown Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? M 2 🗆 No Accident Investigation within 24 hours after death

To the Funeral Director: A

Completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Res- 000 2012

Registrar

DHMH 17 Rev 06-2011

State

800

ORleans St.

Baltimore, MD 2027

30. Marge and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

ORNBLUTH

32. Registrar's Signature

			Amend #25,	se Type or Print 26 Per MD 69 State of Mary	in Black	c Indelik	le Ink.	Ensure A	All Copie	es Are	Legible.			
			1 - For State Registrar	otate of Mary		Certifica:			vientai rij	Reg. No.	2012	2445	9	
	Physic Med		1. Decedent's Name (First, Middle, Gerald Clar.	,	arles				2. Date of D Month	eath Day		3. Time of Death 7:004 M	1	
	Exam		4a. Facility Name (if not institution,			4b. City	1.1	cation of Death		4c. (	County of Death		_	
	Funera		5. Social Security Number	3. Sex 7. Age (In	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth							Birthplace (State or Foreign		
	Directo		216-36-8666 Usual Residence of Decedent 10a. State 10b. County	1 XM 2 □ F	79 Yr		Days   F	lours Min.	(Month, D		Cou	MD		
	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Director	Ms	100	34/H	mon			-			10d. Inside City Limits 1 Yes 2 □ No		
	with the s 23a o	Funeral	10e. Street and Number	vil Avenu	IP.	10t. Zi	ip Code	11215		10g. Citiz	ren of What Cou <i>US A</i>	intry?		
S	r death r items iner m	/ Fun	11. Marital Status	12. Was Decedent Ever Armed Forces?		13. Was Dece If Yes, spe	edent of Hispa ecify Cuban	nic Origin? (Sp lexican, Puerto	ecify Yes or No Rican, etc.)	- 1	4. Race - Ameri Black, White		_	
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uar (6 21215-0036	thin 72 h ene. <b>than "na</b> he Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4 or 5+)	(G	e. DO NOT us	ork done dunir se retired)	g most of work		16b. Kin	d of Business/Ir	R. //		
$\mathcal{Q}_{\mathcal{L}}$	Ild be filed within Mental Hygiene. Iarked other tha atic event, the I	To Be (	17. Father's Name (First, Middle, La.	1		ase	18	Mother's Warn	ne (First, Middle	, Maiden St	urname)	Da/Hmon	2	
A Maryla	2 should be the and Men 7 is marke traumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. M	lailing Addres	Street and	カセイナ Number or Rus	rude Numb		erson own, State, Zip			
	1 and 2 st of Health a item 27 is		Betty A. Qua	rles/Wife	57	210	ongu	- / /	enve.	· ) .	. /	MD 21215	5	
Je ra Baltimore,			20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	Ob. Place of Di Demetery, o	isposition (Na crematory or	other place)	/	Date	20c. Loc	ation - City or T	own, State		
高い	permit. Page Department o Important: If any injury or once,		4 Donation 5 Other (Sp. 21 Signature of Funeral Service Lic		77/60	22. Name a	nd Address of	Facility Vau	shi C	3neen	e, Finer	al Services		
	9 9 E 29		Vanche (	Mure	dash Dass	8728	Libe	My R	sad Ro	indal		mo 21133	- 23	
	Physician/	,	23a. Part 1. Enter the disease, or conshock, or the stallure. List only immediate Cause (Final disease or condition	(		enter the mod	LA.	ich as cardiac (	or respiratory a	rrest,		Approximate Interval Between Onset and Death		
-	Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	my	MMIN					Apore		
		ner	Sequentially list conditions, if any, leading to immediate	b. Hypert	sequence of):	1						Years	-	
	executed an and ırial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	on an an an									
00	e be exe ysician ne burial		resulting in deathy Last	d	sequence oi).									
68760	ertificat ding ph se as th	/Mec	IF FEMALE:	23c. If yes, outcome of pre	ananav									
Вох	To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buriar	Completed by Physician/Medical	23b. Was decedent pregnant In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1  Live Birth 2  4  Pregnant at time 9  Unknown	Fetal death	3				23	3d. Date of deliv Month	rery Day Year	1	
P.O.	s that the	by Pt	Part II. Other significant conditions	contributing to death but not	resulting in th	ne underlying	cause given in	Part I.	23e. Did t	obacco use	contribute to the	he cause of death?	٦	
rds,	require been sig	eted	Cerebrovascula	r disease,	pseud	oacho	ndrop	kasia				bably 4 🗹 Unknown		
2 Seco	The law tre has b	ompl								ormed?	death?	psy findings available empletion of cause of		
tal F	cian; T sertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:	-			of Death (Check	1 \(\superset \text{Yes}\)	2 No	1 🗆 Yes	2 L No		
of Vi	Physical this ceral dir	e: To	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2	ER/Outpa		OA Other: 4		me Kanana Residente Para Residente P		Other (Specify	)	-	
Jon o	eath. or: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigat	(Month, Day, Year	) injur	y M	work?	2 🗆 No	zou. Describe i	low injury o	ccurred			
$\#$ 25, $\mathcal{L}$ 0 Division of Vital Records,	tal or Attendirs after death		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine			street, factor	y, office		28f. Location (\$ City or Tox		Number or Rural	Route Number,		
	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check 2 L Medical Exa	nysician: To the best of my kn miner: On the basis of examina urse Practitioner: To the best	ation and/or inv	estigation, in	my opinion, de	ath occurred at	the time date a	and place at	nd due to the car	use(s) and manner stated	d.	
	Vithi Com		29b. Signature and title of certifier	1		290	License nun	ıber			signed (Month,			
	)		30. Name and address of person wh	completed cause of death (	tem 23a) (Type		5249	4		07/0:	2/12		4	
			Mark T. Hughes, M	0 601 North	Carolin		et Room	7143	Baltim	one, t	1 ary and	12(287-0941		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 1	32. Registrar's Sig	gnature	back	j			1	I			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 29, 2012 Mary Virginia Reedy 3:47 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country. Virginia Days Hours Months 1 □ M 2 🕱 F Aug. 14, 1926 212-24-6510 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Harford 1 XYes 2 No Bel Air 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 925 Moores Mill Road Bel Air USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give White Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service 12 Public Schools and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f. Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Johnny G. Hubble Sr. Lenora R. Blankenbeckler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. David Reedy / Son 1273 Boyd Road, Street, Maryland 21154 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Bel Air Memorial Gdn. 8/2/2012 Donation 5 1 Bel Air, Maryland Sig ure of Funeral 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ mohable disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for each consequence of cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year ed by the a 9 \ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has bage 2 s autopsy performe Yes 2 2  $\square$  No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' Division 1 Tyes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one certifie 29d. Date signed (Month, Dav. Year) 1)0057223 2012 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sarrueto 500 Upper MO Ja. (m 111 31. Date filed (Month, Day, Year)

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State Registrar DHMH 17 Rev 7/2009

**ORIGINAL** 

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Luis E. Salazar-Reyna 1- For State

2012 24462

		Registrar				Certino	ale of	Dealli				Reg. No.			
Physician/ Medical Examine															
		4a. Facility Name (i Meritus Medica		give street and nur	mber)		3	b. City, Town, o	or Location o	of Death			. County of <b>Vashing</b> t		
Funeral Director		5. Social Security N 579–55–2	438	6. Sex 1 XM 2 F	7. Age (II	n yrs. last bi 19	rthday) Yrs.	If Under 1 Ye Months Da	ear If Unders	_	8. Date of B 8/16			Cou	hplace (State or Foreign untry) XICO
nd show any cc.		Usual Residence of 10a. State MD	10b, County	ington	100	c. City, Towr	or Location								10d. Inside City Limits  1 X Yes 2 No
the Maryland a or 28a-f sh tiffed at once Director		10e. Street and Nur 111 Lee						10f. Zip Code <b>2174</b>	0			-	zen of Wha exico		ry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Bygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		11. Marital Status 1 Never Marrie		1 Yes	orces?		If Y	Decedent of Hes, specify Cub	an, Mexican	n, Puerto Ri	can, etc.)		White,	etc.	can Indian, Black,
Lhours after "natural", Examiner		Widowed     Secondary/Secondary	ducation (Speci	rced if Yes, Give Yes or Dates: ify only highest grad College (1	de complet	ted) 16a.	Decedent	Yes 2 \( \) Note that Note	ation (Give k	and of work			Specify: (ind of Busi		spanic dustry
MD 21215-0036 nd 2 should be filed within 72 hours ath lith and Mental Hygiene nn 27 is marked other than "natural" sunnatic event, the Medical Examine To Be Completed by	-	<b>7</b> 17 Father's Name (				5	Serve	r	18.Mother	's Name (F	irst, Middle,		estau Gurname)	ran	t
21215 ould be file ould be file ounced it s marked fic event, ti		Rodolfo 19a. Informant's Na				19	b. Mailing	Address (St			abel rai Route Nu				
e, MD and 2 sho fealth and item 27 is traumati		Avelardo 20a. Method of Disp	osition			20b. Place	of Disposit	E. Stat			Athen Date				Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite			Other Spe	3 X Removal fr	om State			er place) el <b>Cemet</b> ame and Addre			/2012				a, Mexico
Physician	1	LPashu 23a. Part I. Enter th	- Bow e disease, or c	omplications that ca	aused the o	death. Do no	41	07 Wilk	ens A	venue	e, Bal	timo	re, M	ary	land 21229  Approximate Interval
/Medical Examiner		failure. List on Immediate Cause (F or condition resultin		a. Multiple In  Due to (or as a		ence of):									Between Onset and Death
ner		Sequentially list con if any, leading to im cause. Enter Unde	mediate	Due to (or as a	conseque	ence of):				, , , , , , , , , , , , , , , , , , ,					
uted d ansit Examine		(Disease or Injury to	nat initiated	Due to (or as a	conseque	ence of).									
68760, certificate be executed nding physician and seas the bunial - trans sian/Medical E:		UNPENDED		AMENDED	outcome o	of pregnancy						230	i. Date of d	elivery	
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P.O. I es that the signed by the be detached by the detached by the bed detached by the bed by Ph		Part II. Other signi	ficant conditio	ns contributing to	death but	not resulting	in the und	derlying cause (	given in Part	:1.		tobacco u es 2			ne cause of death? ably 4 X Unknown
Division of Vital Records, P.O. Box To the Hosp halo rattending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the after completely filled in by the funeral director, page 2 should be detached for uedical Certification: To Be Completed by Physic											peri 1 X Yes	opsy formed?	pri de		opsy findings available ompletion of cause of 2 No
ital ician: certii redor		25. Was case refer examiner?		Hospital: , ,		a [V] =D(0	. do all and		Other	_		ا میناد	6	Other.	
on of Viring Physical Company of the company of the		1 X Yes 7. Manner of Death 1 Natural	No No Sendir	28a. Date FOUN	of Injury Day,Year)	28b. FO	Time of In UND:	jury 28c. In	ury at Work	(? 20 No S	Bd. Describe ubject pa	ssenge	ry occurred r of vehic	d	volved in
Division o  To the Hosp kal or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Pleaten by the funeral Certification:		2 X Accident 3 Suicide 4 Homicide	Investi 6 Could determ	not be 28e. Plac		- At home, I	55 hrs arm, street	t, factory, office	building, et	ic. 2		(Street ar State) H	nd Number lagerstov	wn, M	
To the Hosp within 24 hos To the Fune completely fi		29a. Certifier 1		/sician: To the besiner: On the basis of and manner s	of examina					e, and due	to the caus	e(s) and r	manner as s	stated.	
N N N N N N N N N N N N N N N N N N N		29b. Signature and	title of certifier	· King	TI	ly ju	(A)		Se number	OSM	E		Date signed Ily 24, 20	•	th, Day, Year)
B		Name and address Theodore M	I. King, Jr., I	MD. Assista	nt Medic	al Exami	ner 90	00 W. Baltim	nore Stree	et, Baltin	nore, MD	21223			li.
State Registra		AUG 0	1 2012	32. Re	egistrar's S	6	لعظمه	,							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0338 MIT 2012 Medical 4a. Facility Name (if not institution Examiner 4c. County of Death more 8. Date of Birth yrs. last birthday) **Funeral** Birthplace (State or Foreign 1 🙀 M 2 🗆 F **Director** himore or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Funeral Director (timore 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? or items 23a U.S.A. 2122 203 . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces' 1 K Yes 2 I If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 Specify Black 1 ☐ Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Louse 2\_ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၉ loten 24 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 Department of Important: If it any injury or o of Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) -2012 Lakeworth A. Name, and Address of 21. Signature Funeral Service Licent Service 23a. Part 1. Enter the disease, or complications that caude the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ astrointes tina disease or condition resulting in death) Medical Due to (or as a consequence of) Hular **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: Inpatient 2 ER/Outpatient 3 DOA 은 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at injury work?
1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation after.death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) Signature and title of certifie Donnes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 N. Urleans St. Baltimore MD 21287 K lar 31. Date filed (Month, Day, Year State

DHMH 17 Rev 06-2011

Registrar

AUG 0 1 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, item 5 per fh g930 8-10-12 yt
State of Maryland / Department of Health and Mental Hygiene

state amend item 18 per fh g930 8-16-12 yt
Registrar

Certificate of Death

Reg. No. 2 Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06:01AM Benjamin Smith 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore Social Security Number 217–32–3002 If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours 11-1-1944 Country) Director 1 X M 2 □ F 67 MD Known as Benjamin Smith Maryland 21215-0036 item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore n/a 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6310 Greenspring Avenue Apt. 201 21209 USA 12. Was Decedent Ever in U.S.
Argued Forces?
1 ⚠ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black. White, etc. 1 Never Married 2 Married Completed by Specify: African-American 1 ☐ Yes 2 No Specify: 3 Widowed 4 XDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Sales Lucent Technologies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ should be 1 Theodore Lunn Virginia Smith Williamson permit. Page 1 and 2 should Department of Health and Mt Important: If item 27 is mark any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rabiah Smith/Daughter 9536 Nathaniel Lane, Land O Lakes, FL 34638 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 8-1-2012 Baltimore, MD 4 Donation, 5 Other (Specify) 22. Name and Address of Facility Lie Fine ral Forme P.A. of Balto. Co. 21. Signature of Funeral Service Licensee 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Severe electrolyte disease or condition resulting in death) imbalance Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a some equation of): hin 24 hours after death. **the Funeral Director:** After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant at time of death 9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellins type II 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of injury 28d. Describe how injury occurred 28c. Injury at 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 29b. Signature and title of certifie RES -000 JULY, 27, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore MBBS 31. Date filed (Month, State Registrar

8 mitdred Baltimore. Maryland 21215-0036 SchlichT Division of Vital Records. P.O. Box 68760

		•	For State Registrar	State of Ma	•	Certificat			ALIGITY		Reg. No	0.0	12	21.1.	51
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Vegr										ear	3. Time of Death	
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death				31 2012 2 4c. County of Death			210 A	M
			FRANKLIN SQUA	PITal	Rosedala				2		Baltimore				
	Funeral Director		5. Social Security Number 212-20-5944  Usual Residence of Decedent	(In yrs. last birtho	Months rs.	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Year May 2, 19		9. Birthplac Country)		ace (State or Fore	ign	
3	permit. Page 1 and 2 should be lined within 72 hours after deaft with the Maryland pagetrhent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director										10d. Inside City Limits			
			Maryland Baltimore		Baltimore County  10f. Zip Code					1 ☐ Yes ※X No  Og. Citizen of What Country?					
44 447			533 Dale Avenue		21206					USA_					
		by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3★★Widowed 4 ☐ Divorced  12. Was Decedent Ever in Armed Forces?  1 ☐ Yes ★1★ No If Yes, Give Year or Dates			n U.S. 13. Was Decedent If Yes, specify (			of Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.)  No Specify:			14. Race Black, \ Specify:	tc.		
		oletec	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation						16b. Kind of Business/Industry			
		Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 10 yrs. N/A			(Give kind of work done during most of working life. DO NOT use retired)  Homemaker					Homemaking-Own Home				
		Be	17. Father's Name (First, Middle, Last) Henry Roeder		Onicinake	(First, Middle, Maiden Surname) te Shanahan				WIT TIOME					
			19a. Informant's Name/Relationship (Type Joseph M. Schlicht,			Mailing Addres									7
5			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of I cemetery	Disposition (Na.	me of other place			ate	20c. L	ocation - Cit	ty or Tov	vn, State	
	int. rag	ķ	4 Donation 5 Other (Specify)  Gardens of Faith 8-4-2012 Baltimore, Md.  21 Data of Funeral Service Licensee  22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236										_		
វ	Depar Impor any in	: 1	Mother 068	30h ( S	2							1. 212	36		
PI	nysician Medical Examiner	2 2	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.			le of dying	, such as d	cardiac or	respiratory arr	rest,			Approximate Interval Between Onset and Death	
) [			resulting in death)	Seps Due to (or as a C-Dif											
		iner	Sequentially list conditions, if any, leading to immediate	consequence of											
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the death of		Physician/N	1 Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 Ves 2 No 9 Unknown  1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								Month Day Year				
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	been s	letec								24a. Was	24b. Were autopsy findings available				
Po da	ate has	Completed								autop perfo 1 🗌 Yes	rmed?	prio dea	r to con	pletion of cause o	of
	ector,	Be	25. Was case referred to medical examiner?	espital:			-	ice of Deat	h (C <i>h</i> eck			•			
Dhye	er this c	e: To	Hospital: 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred												
poline	eath. or: Afte	ficat	1												
100	rs after de al Directo ed in by t	d Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	n, street, factor	street, factory, office				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Hoopi	n 24 hou ie Funera	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
+ 01	withi To th	17.	29b. Signature and title of certifier			29	c. License		,		29d. Da	ate signed (N	fonth, D	ay, Year)	
	DAIL		30. Name and address of person who con	Cre har	ath (Item 22a) /Ti	me Print)	D77	174	8		71	31/15			
	10 SV			afik ch	rehab	900	o FI	RANK	Lin	Squa	62	DRB	Balt	o md 212	237
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	11									

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State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number)
10516 Marriottsvile Road 4b. City, Town, o or Location of Death Examiner 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
N. C. 5. Social Security Number 239-20-0363 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Days 1 🗆 M 2 🗀 F 87 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Randallstown 10h County 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes ŽŽNo 10e. Street and Number 10516 10f. Zip Code 10g. Citizen of What Country? Marriottsville Rd. Funeral 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces 1 ☐ Yes 2 ☒ No If Yes, Give Specify Black <u>چ</u> 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Home maker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Enos Young Katie Mae Moore 19a. Informant's Name/Relationship (Type, Print) Cheyenne Allen/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 10516 Marriottsville Rd Randallstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date metro Crematory or other place) 1 🗌 Burial 2 🖾 Cremation 3 🔲 Removal from State 8/1/12 Catonsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 21 Signatur ColFi nural Service Lin Z 20a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Dav Year Pregnant at time of death cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform after death.

Director: After this certificate I 2 No 2 4 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 **W** No 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6934 AVI

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 28<sup>ay</sup> 2012 Virginia Early Torgerson 2:32 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours. (Month, Day, Year) Director 217-20-2589 1 □ M 2 🔀 F Oct. 5, 1926 85 North Carolina Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland Parkville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8736 Oakleigh Road 21234 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify. 3 Widowed 4 St Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Specialist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F မ is marked Glenn Edwin Tilley Bettie Mae Early 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Torgerson / Sop 8736 Oakleigh Rd., Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any Injury or oth Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) from State Bel Air Memorial Gdn. 8-1-12 Bel Air, Maryland 21. Signature of Futeral Service Licens <sup>22</sup> Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 Part 1. Enter the disease, or complic that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) igned by the attending physician and be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Castrointes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an After this certificate To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5  $\square$  Pending work? 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Deptifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated nly one) 29b. S 29d. Date signed (Month, Day, Year) D0071287 30. Name and address of person who completed cause of death (Item 23a) (Type Print) #4105, Baltimore, State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-05498 State of Maryland / Department of Health and Mental Hygiene Phillip A. Weatherford 2012 24468 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 23, 2012 0640 hrs Medical Examiner Phillip Weatherford Α. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore Baltimore If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Davs Hours Director 1 X M 2 F Yrs 12/10/1959 MD 214-80-2442 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f sho injury or nither traumatic event, the Medical Examiner must be notified at once. MD N/ADirector 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 4127 Woodhaven 21216 USA Avenue uneral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 2 Married 1 X Never Married Yes ũ f Yes, Give Year 1 Yes 2 X No specify: Specify: 3 Widowed Black 4 Divorced 至 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Funeral Service Mortician 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estelle Jeffries Weatherford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fairmount Court, Shrewsbury, Pa. Weatherford Robert 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 7/31/2012 BAltimore, Md. 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Estep Brothers Funeral Service 1300 Eutaw Place, Baltimore, 21217Md Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED attending physician or use as the burial death certificate be Box 68760, 23d. Date of deliver IF FEMALE: 23c, If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown the law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ě 1 Yes 2 No 3 Probably 4 Unknown ٦ Completed Records, ficate has been s page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical of Vital å examiner? Hospital: 1 🗸 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA this 1 Yes 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Jul 23, 2012 Subject stabbed and cut 0243 hrs 1 Natural Division 1 Yes 2 ✔ No 5 Pending by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 3 Suicide 6 Could not be or Town, State) 10700 blk Pulaski Highway, White Marsh, MD To the Hospital
within 24 hours a
To the Funeral I (Specify) Local Street determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. July 24, 2012

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

OCME

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

**ORIGINAL** 

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vernon Lloyd Weaver 5:35 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Days 1<u>918</u> 1 🔀 M 2 🗆 Hours Director 218-07-9172 Montana 94 Jan. Usual Residence of Decedent d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3056 Harmony Church Road 21034 USA 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married \$ Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3₺ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technical Specialist Computer Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Nathan Lloyd Weaver Ermina Clark Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is Christena Smith / Daughter 6372 Pilgrams Rest Road, Warrenton, Virginia 20187 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
ROSE Hill SVCS. LLC 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 7/31/2012 Bel Air, Maryland Donation 5 Other (Specify) 21. Sc n ture of Funeral 22. Name and Address of Facility ervi e l McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. bleedin Immediate Cause (Final Gastroint Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). and -trar resulting in death) Last Due to (or as a consequence of): burial-1 physician at the burial-Physician/Medical death certificate be 687 IF FEMALE: use 8 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Box in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Dav Year □ Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 this certificate 1 Yes 2 No 25. Was case referred to medical Vital Physician: Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Division of 27. Manner of Death al or Attending P s after death. I Director: After t Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide þ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital or the in 24 hours after the Funeral Direction pleted filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, To Wit com 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's Signat AUG 0 1 2012 Registrar

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phys Me Exa To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Euneral Director After this certificate has been sinned by the attending physician and Division of Vital Records, P.O. Box 68760

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kamin	er	4a. Facility Name (if not institution, give street and i	,	4b. City, Town, o	or Location of Death		4c. County of Deat St. Mary	
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important: It tell 27 is marker other than induced, on tells sea or sear show any injury or other traumatic event, the Medical Examiner must be notified at once.	ral D	10e. Street and Number 3041 Patuxent River Ro	ad	10f. Zip Code 21035		10	g. Citizen of What Co USA	untry?
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rtic e	To	Adolph Abend			Louise Sl	hmit		
anma		19a. Informant's Name/Relationship (Type, Print)	19k	b. Mailing Address (Street	and Number or Rural	Route Number, C	ity or Town, State, Zip	Code)
her tr		Steven Abend/ Son		3041 Patuxen				·
orot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr	om Statecemete	of Disposition (Name of ery, crematory or other pla	ice)		c. Location - City or	
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12-04811 Rodina Attya Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Funeral	٦	5. Social Security N	lumber	6. <b>S</b> ex	7. Age (In	yrs. last birthday)	If Under 1		nder 24Hrs.	_	irth (MM/		9. Birt Foreig	hplace (State or
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Division of Vital Records, P.O. Box 6876 tall or Attending Physician: The law requires that the death certificate rs after death.  al Director: After this certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the	Physician/M	1 Yes 2 N	No 9 🗹 Unk		nant at time o	of death 5 O	her (Specify)				1			- 9
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S40	to	Melissa Bras			dical Exa	miner 900 W	. baitimore	orreet,	Daitimor	e, MD 212	23			
Sta Registr	ar	31. Date filed (No.	8 2012		-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Muly Physician/ Irving Victor Marken Abb 15° 2012° 3:00 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Woodbine 2703 Woodbine Road If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Country) Mary land 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Jan. 6, 1926 Hours 216-22-8537 86 Director 1 X M 2 □ F er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🎖 No Lisbon Maryland Howard i 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21797 United States 2703 Woodbine Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant. If item 27 is marked other than ury or other traumatic event, the Nury or other traumatic event the Nury or other traumatic event the Nury of Nury event the Nury event eve Law Practice Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Irving Augustus Abb Dorothy Marken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17550 Annapolis Rock Road, Woodbine, MD 21797 Chris Abb / Son timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1.
Department of 1.
Important: If its any injury or of once. July 18. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Mount Olivet Cemetery 2012 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licen Keeney and Basford PA Funeral Home, 106 East Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Pnysician/ Crone disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner abere Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and the burial-transit evsion or Attending Physician: The lew requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phone of the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death sate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 performed 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 2 🗷 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) D0058756 6th 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 186 Thomas Johnson Drive, Ste 105, Frederick, MD 21702 Har<u>pal Mangat</u> 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24473 1 - State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2012 Physician/ FIELDEN REECE BISHOP  $\mathbf{P}$  M JULY 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death QUEEN ANNE'S CENTREVILLE QUEEN ANNE'S COUNTY HOSPICE CENTER If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Numbe 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director 229-32-0657 1 X M 2 🗆 F 82 JAN. 23, 1930 **VIRGINIA** Usual Residence of Dece ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director CHESTER **OUEEN ANNE'S** MD 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21619 UNITED STATES 109 WIDGEON WAY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc X Yes 2 No 1949or þ 1 Never Married 2 Married within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 ☐ Divorced Specify: 1954 WHITE Completed Year or Dates عدد عدد Ar than "he. "he Medical F Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) filed within College (1-4 or 5+) 12 MEAT INSPECTOR FOOD marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 should be file r and Mental F 2 DELLA STURGILL FIELDEN R. BISHOP SR. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 109 WIDGEON WAY, CHESTER, MD 21619 CARRIE TALBERT / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State STEVENSVILLE CEMETERY 07/17/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen PLLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DESTIVUTUE disease or condition me Ven 5 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the 38 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year signed by the at d be detached for P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 1 🗌 Yes 2 No To the Hospital or Attending Physician; funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 K Other (Specific Other: 1 Yes 2 No.No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and titl 29c. License number 29d. Date şigned (Month, Day, Year) 4+19 and address of person who completed cause of death (Item 23a) (Type, Print) Contreville 2540 SEPFRE UKENS Contreville

State

Registrar

31. Date filed (Month, Day

16

32. Regist r's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 16 Charles M. Browning 2012 9:00 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9 Church Street Oakland Garrett 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Birthpu Country) MD Hours Min. (Month, Day, Year) 08/06/1932 Director 1 M M 2 | F 79 217-28-0315 Yrs item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Oakland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 9 Church Street 21550 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura!", any injury or other traumatic event, the Medical Exar If Yes Give 3 Divorced Specify. Completed ar or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Bus Driver** Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Van Browning Ruby Pearl Luhl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Browning / Wife 9 Church Street, Oakland, MD 21550 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/20/2012 Deer Park, MD Deer Park Cemetery Signature of Funeral Service Lice 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Anaplastic large cell lymphoma 2010 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Dav signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Pituitary tumor 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 🗌 Yes\_ 1 ☐ Yes 2 ☐ No director. 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 M No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accider
3 Suicide 5 Pending Work? 1 ☐ Yes 2 ☐ No eral Director: A Accident after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 7/19/2012 H26154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Daniel Miller 69 Wolf Acres Drive Oakland, MD 21550 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

JUL 19 2012

Box 68760

P.0.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day M97th Russel H Bowser 2012 8:30 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dennett Road Manor Nursing Home Oakland Garrett Social Security Numbe If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country)
 A Age (In vrs. last birthday) If Under 24 Hrs **Funeral** Months Hours Min (M97070371 192)1 184-18-9434 90 **Director** Usual Residence of Decedent 28a-f show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Mt. Lake Park MD Garrett 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 509 E St. 21550 **USA** 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Armed Fo d Forces Black, White, etc. permit, Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced 1942 - 1945 White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Parts Sales 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5766 Pleasant Hill Road, Milford, OH 45150 Mary R. Pelopida / Niece 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 1 🗖 Burial 2 🗌 Cremation 3 🗌 Removal from State 7/14/2012 Oakland, MD Garrett County Memorial Gardens 4 Donation 5 Other (Specify) Signature of Funer Service Licensee 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 ... nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Inset and Death 23a. Part 1 shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons ice of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exam death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Year 5 Other (specify) Month Day Pregnant at time of death per 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown signed by ti P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an To the Hospital or Attending Physician: The law page 2 autopsy 25. Was case referred to predical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 5 Pending Natural within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation Could not be Suľcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and on investigation, army opinion, source data and place, and due to the cause(s) and manner as stated Certifying Nerse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DISDR333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson 311 North Fourth St, Suite II Oakland, MD 21550 31. Date filed (Mooth, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#5perFH, G930, 8/28/2012, WS
State of Maryland / Department of Health and Mental Hygiene 21,477 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ July 2012<sup>ear</sup> 11, 11:59 P M Margaret Jane Bingham Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 536 East Mountain Road Knoxville If Under 1 Year | If Under 24 Hrs Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country Director 1 M 2 X Yrs Sept.29, 1920 91 Maryland Usual Residence of Deced Mode 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f s 1 Yes 2X No Maryland Frederick Knoxville or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 536 East Mountain Road 21758 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ori þ 1 Never Married 2 Married within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. 'natural", 3 Widowed 4 Divorced Specify: Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ School Teacher Education traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ၉ Myrtle Lowry Roy Bingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other traconce. 536 East Mountain Road, Knoxville, MD 21758 Iris Young / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State ţ. X Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 7/16/2012 Cemeterv Knoxville, Maryland Knoxville 21. Signature of Juneral Service Licen 22. Name and Address of Facility Stauffer Funeral Home 1100 North Maple Ave., Brunswick, MD 21716 1. Enter the disease or heart failure. List or ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Death shock, or beart failure. L nly one cause Immediate Cause (Final MKLOVA Physician/ disease or condition resulting in death) Medical as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) -transit that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OMC 3 Probably 4 Unknown Completed neec Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) No Hospital 1 Yes 2 Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) Manner of Death

Natural

Accident funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Funeral Director: After isompletely filled in by the funer 5 Pending iniurv work? 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (Check igation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: th occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29d. Date signed (Month, Day, Year) one ed cause of death (Item 23a) (Type, Print) 300 West Ninth St./ Frederick, Maryland Kaufmann 21701 Robert L. 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryla		artment of F <i>tificate of D</i>			211	12 26478
			Registrar  1. Decedent's Name (First, Middle, Last	)	Cer	illicate of L	Jean I	2. Date of Dea	Reg. No.	3. Time of Death
Н	Physicia Medic		Thomas	s William But	1er			July 1	3, <sup>Day</sup> 2012	year 0851 M
ora.	Examin	er	4a. Facility Name (if not institution, give s Suburban Hosp:			4b. City, Town, or		h	4c. County of	
1112	Funeral		5. Social Security Number 6. Se.		last birthday)	If Under 1 Year	thesda If Under 24 Hrs		1 9	tgomery  9. Birthplace (State or Foreign
	Director			XM 2 □ F 84	Yrs.	Months Days	Hours Min.	(Month, Day, May 28		DC
	and show lat	or	Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo	cation		Hay 20	, 1920	10d. Inside City Limits
	Maryl. 28a-f otifiec	irect	Maryland Prince G	eorge's			Hyat	tsville		1 🙀 Yes 2 □ No
	ith the 23a or at be n	ralD	10e. Street and Number	1		10f. Zip Code	782		10g. Citizen of Wh	at Country? I States
	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	3007 Jamestown R	12. Was Decedent Ever in U	.S. 13.	Was Decedent of Hi	spanic Origin? (S	pecify Yes or No-		American Indian,
36	after d	by	1 Never Married 2 🕱 Married	Armed Forces? 1 □XYes 2 □ No If Yes, Give		f Yes, specify Cuba I ☐ Yes 2 🔼 No		to Rican, etc.)		White, etc. African
21215-0036	atural	Completed	3 Widowed 4 Divorced	Year or Dates.		lent's Usual Occupa			16b. Kind of Busi	nerican
215	in 72 h e. nan "n	duic	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done a O NOT use retired)		rking		•
121	d with Hygien ther tl nt, the	Be C	17. Father's Name (First, Middle, Last)	1		Mail C		(F) 1 4 4 1 4 1 1 1		ernment
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Manyland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	인	11. Father's Name (First, Middle, Last)			unk.	18. Mother's Na	me (First, Middle, N Mable (	. Butler	•
lary	should and M	77	19a. Informant's Name/Relationship (Typ			ng Address (Street a				
	and 2 s Health tem 27		Lula M. Butler -			Jamestow		<del> </del>	20c. Location - Ci	
Baltimore,	Page 1 nent of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crer	natory or other place t Cemeter		y 20, 2012		gton, DC
3alti	permit, Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	e Lat	22	. Name and Addres	s of Facility St	tewart Fu	neral Ho	ome, Inc.
Ë	<u> </u>	- 1	23a. Part 1. Enter the disease, or comp			4001 Benr				
	hysician/		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.				150-1-100-00-00		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consec		ey AR	(C)Cy	DISER	737	-
V	Examiner	eľ	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consec	ruonco ofi:					
	uted d ansit	Examiner	cause, Enter Underlying Cause (Disease or injury	Due to (or as a consec	querice oi).					
	sate be executed physician and the burial-transit	al Ex	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
200	physic the bi	edical		d						
687	certific nding use as		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr	iancy	J			23d. Date	of delivery
Вох	hat the death certifficed by the attending detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)	у		Month	n Day Year
P.O.	nat the ed by t detach		Part II. Other significant conditions col	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	pacco use contribu	ute to the cause of death?
JS, F	v requires that been signed to should be det	ed by		Ÿ				1 □ Y	es 2 <b>9</b> No 3	☐ Probably 4 ☐ Unknown
of Vital Records,	aw req as bee 2 sho	Completed						24a. Was a	n 24b. We	ere autopsy findings available or to completion of cause of
Re	sician: The law i certificate has t lirector, page 2 s		OF Management and the second and					perform 1 Yes		ath? Yes 2 No
Vita	ysician: s certific director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐	R/Outpatier	Otho	r:	<i>ck only one)</i> Home 5 □ Reside	ance 6 Other	Specifid
of	ng Ph fter thi uneral		27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at		w injury occurred	opecny
sion	ittendi death stor: A y the f	Certificate:	2 Accident Investigation 3 □ Suicide 6 □ Could not be	28e. Place of Injury - At h	ome form str		Yes 2 ☐ No	20f Leastion /Ct	root and Number	or Rural Route Number,
Division	al or A s after al Direction b		4  Homicide determined	building, etc. (Speci.		ser, ractory, office		City or Town		or Hurai Houte Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within L4 Hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and formpletely filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Medical	(Check 2/ Medical Examin	cian: To the best of my knower: On the basis of examination	on and/or invest	tigation, in my opinio	n, death occurred	at the time, date an	d place, and due to	the cause(s) and manner stated.
	o the	Ň	only one) 3 Certifying Nurse	Practitioner: To the best of	my knowledge,	death occurred at the 29c. License	ne time, date and p	place, and due to the	e cause(s) and man 9d. Date signed (A	nner as stated.
			•	Ben, n	מי	000	571:		7(13	
	45m		30. Name and address of person who co				77 - 161	20050		
	Stat	e	Truông Bao 10110 31. Date filed (Wonth, Pay, Year)	Molecular Dr			11e, Md.	20850		
	Registra	ar	9077 95	116 Genera	p. 12	entel				

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Alishis Isistm Basell Mobion

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		ar yrarra 7 s	Certif	icate of De	eath		Reg. No.	2012	2667
	Physicia	ın/	1. Decedent's Name (First, Middle, Las	*					2. Date of Dea		Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give	arian H. Ba	assett	- 14	o. City, Town, or L	agation of Dooth		12, Day 20		12:15 PM
	Examin	er	St. Thomas More		omplex	4		attsvil			inty of Death	George's
Ī	Funeral Director		5. Social Security Number 6. S		e (In yrs. last birti	,,,	Under 1 Year		8. Date of Birt July 2	th	g. Birth	place (State or Foreign
			Usual Residence of Decedent						1001) 2.	,		Tary rand
	ryland -f sho ied at	Director	10a. State 10b. County		10c. City, Town	or Locati						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ne Ma or 28a notif	Dire	Maryland Prince (	George's			Cap 10f. Zip Code	itol He	ights	10g Citizen	of What Cou	
	with the 23a cast be	Funeral	6806 Walker Mi	11 Road #3	01			743			ited S	
	items items	Fun	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was	Decedent of Hisp s, specify Cuban,	anic Origin? (Sp	ecify Yes or No-	14. F	Race - Americ	can Indian,
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates.	No		Yes 2 X No		, , , , , , , , ,		Black, White,	
5-0	2 hou "natu edical	Completed	15. Decedent's E (Specify only highest gr		16a.	(Give kind	's Usual Occupati of work done dur		king	16b. Kind o	f Business In	dustry
72	ithin 7 ene. r than	Com	Elementary/Seconday (0-12) 12th	College (1-4 or 5	+)		OT use retired) sed Prac	tical N	urse	l F	Private	e
D D	illed wall Hygin I othe	Be	17. Father's Name (First, Middle, Last)				1	8. Mother's Nan	ne (First, Middle,			
ylar	ld be l Menta iarked atic e	욘	J. 0	liver Hill					Mario	on Sim	ms	
Mar	shou hand 7 is m traum		19a. Informant's Name/Relationship (7	, ,			ddress (Street and					
e,	and and tealt tem 2		Deborah Wincheste 20a. Method of Disposition	er - Daugh	20b. Place of						Height on - City or To	s, Maryland
O E	age 1 ent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		cemeter	y, cremato	ory or other place)  Cemete	July	Date 21, 2012		-	Maryland
Baltimore, Maryland 21215-0036	permit. I Departrr Importa any inju once,		21. Signature of Funeral Service Licens	see 1	0560	22. Ni	ame and Address	of Facility St	ewart F	uneral	Home,	Inc.
	222 (0 0)	H	23a. Part 1. Enter the disease, or com				001 Benni				on, DC	20019 Approximate
	Physician/	67. 6	shock, or heart failure. List only of Immediate Cause (Final	one cause on each line		~	DISE	are.				Interval Between Onset and Death
أعمسا	Medical		disease or condition resulting in death)	a. Due to (or as a	consequence o	f):	0156	750				YEARS
	Examiner	-E	Sequentially list conditions,	b. =								
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence o	т):						
	execut an and ial-tra		that initiated events resulting in death) Last	Due to (or as a	consequence o	f):				<del></del>		
00	ifficate be executed g physician and as the burial-transit	Medical	•	l d								
68760	# 50 a		IF FEMALE:	23c. If yes, outcome	of pregnancy							
ŏ	hat the death cert ed by the attendir detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live Birth 4 Pregnant at	2 🔲 Fetal death		topic pregnancy ther (specify)				Date of delive Month	ery Day Year
P.O. Box	the de by the ached	hysi	g Unknown	9 🗌 Unknown								
<u>Ч</u>	s that igned   be det	þ	Part II. Other significant conditions c	_	ut not resulting ir	the unde	rlying cause given	in Part I.				ne cause of death?
rds	v requires the been signed should be a	eted	Hypentersion						1			bably 4 V Unknown
Division of Vital Records,		Completed	ANTERIOSCIEN	•	10 VASCU	CAR	DISCAD	<u> </u>		rmed?	prior to co death?	psy findings available mpletion of cause of
a H	sician: The la certificate ha irector, page 2	Be C	25. Was case referred to medical	1C. ENCY			26. Place	e of Death (Chec		2 No	1 🗌 Yes	2 L No
Ž	hysici his ce Il direc	မ	examiner? 1 ☐ Yes 2 K No		ent 2 ER/Out		DOA Other:	4 Nursing H	ome 5 🗆 Resid	dence 6 🗆 C	Other (Specify	)
סר	ding Ph th. After th funeral	ate:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of injur (Month, Day		ijury	28c. Injury at work?		28d. Describe h	ow injury occ	urred	
Siol	Attence death rector: by the	Certificate;	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined		ry - At home, far			s 2 🗆 No	28f. Location (S	itreet and Nur	mber or Rural	Route Number.
DIV	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificeted filled in by the funeral director,		4 - Horniciae determined	building, etc	. (Specify)				City or Tow			
	To the Hospital of y within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 Medical Exam	sician: To the best of iner: On the basis of ex	amination and/or	investigat	ion, in my opinion,	death occurred a	t the time, date a	nd place, and	due to the car	use(s) and manner stated.
	To the within To the compl	Σ	only one) 3 Certifying Nur- 29b. Signature and title of certifier	se Practioner: To the			29c. License ni	umber		29d. Date sig	ned (Month, i	Day, Year)
			Paullan	Juline.	hm		Doi	852	-	JULY	112	2012
	65m		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print	Doi	201		-1/ "	11 -	-DO
	Stat			SE MD 32 Registra	4	vee	asbury	scal H	367150	ille A	102	0/8/
	Stat Registra		31. Date filed (Month Cay, Jear 8 20	12 /2		640	41					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012  $\mathbf{A}^{\mathsf{M}}$ Ju<u>ne</u> 30 8:45 Nancy Amelia Campbell Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hospice of Queen Annes, Inc Centreville Queen Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2**X**□ F Hours 12787T950 **Director** 62 216-56-1254 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if fleen 27 is marked other than "natural", or items 22 any injury or other traumatic event, the Mariana any injury or other traumatic event, the Mariana and Ma 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10122 New Bridge Road 21629 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Health practice Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Phillip Lee Willey Mary Louise Pardoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Willey/brother 4625 Edgefield Rd., Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Spring Hill Cemetery 7/6/2012 Easton, Maryland 21. gnatur 22. Name and Address of Facility Moore Funeral Home, P.A. South 2nd Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregr 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 mor Pregnant at time of death 9 Unknown g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform Yes 1 Yes 25. Was case eferred to funeral director, Be 26. Place of Death (Check only one) examiner 2 No Hospital Other: 1 🗌 Yes HOSPICE HOUS ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

0 3 201

ho completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Frances Jean Cooper 10:00 PM June 26 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Talbot Talbot Hospice Easton 7. Age (In vrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔏 F Days Hours 2/4/1934 **Director** 220-32-1813 78 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Talbot Easton 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21601 USA 29204 Woodridge Drive 12. Was Decedent Ever in U.S. Armed Forces 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 X Widowed 4 □ Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Seafood & Antiques Business owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Turner Fleming Mary Jeidelle Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32662 Meadowlark Lane Daniel Hodgman, III/son Easton. MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 6/30/2012 Greenmount Cemetery Hillsboro, Maryland 21. S'anature Funeral Servici 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South 2nd Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 100 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? detached for Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury after death. Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

29b. Signature and title of certifier

Jorge H. Abrego,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

DHMH 17 Rev 7/2009

within 2 To the I

598 Cynwood Drive Suite 104

01151132

6.28-12

Easton, Maryland 21601

12-05528	Please Type or Print in Black I	ndelible Ink. Ensure All Copi	es Are Legible.
Christopher Lee C	assidy State of Maryland / Dep 1-For state Ce Registrar Ce	artment of Health and Mental Hertificate of Death	
Physician/ Medical Examinei			2. Date of Death  Month Day  July 24, 2012  3. Time of Death  0400 hrs
	Facility Name (if not institution, give street and number)     13246 Wonderland Way	4b. City, Town, or Location of Death Germantown	4c. County of Death  Montgomery
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 217-06-1215 1XM 2 F	last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Mir	
fue	Usual Residence of Decedent  10a. State 10b. County 10c. City	y, Town or Location	10d. Inside City Limits
and show	Maryland Montgomery	Germantown	1 Yes 2 X No
Maryland 28a-f sho ed at once. rector	10e. Street and Number	10f. Zip Code	10g Citizen of What Country?
ith the 1 23a or notifier	13246 Wonderland Way	20874	United States
er death with the Maryland or tierns 23a or 28a-f sh rmust be notified at once Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in L Armed Forces? 1 X Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.
B - H	3 Widowed 4 Divorced If Yes, Give Year 1 Q Q Q Q	5 1 Yes 2 V No specify	Specify White

16a. Decedent's Usual Occupation (Give kind of work done

during most of working life. DO NOT use retired)

Computer Programmer

20b. Place of Disposition (Name of cemetery,

Resthaven Crematory

crematory or other place)

permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examins. Baltimore, MD 21215-0036 Physician /Medical Examiner

To the Hosp hal or Attending Physician: The law requires that the death certificate be executed within 24 bours after death.
To the Puneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the bunal - transit After this certificate has been signed by the attending physician and functal director, page 2 should be detached for use as the bunal - transi Division of Vital Records, P.O. Box 68760,

Physician/Medical ģ Completed å P Certification: Medical

Michael Cassidy 19a. Informant's Name/Relationship (Type, Print ) Yvonne Cassidy / Wife 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify 21. Signature of Euneral Service Licenses

Se prentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated

events resulting in death) Last

23b. Was decedent pregnant in the

Part II. Other significant conditions

25. Was case referred to medical

29b. Signature and little of certifie

5 Pending

6 Could not be

Investigation

determined

1 X Yes

27. Manner of Death

1 X Natural

2 Accident

4 Homicide

3

Suicide

X UNPENDED

past 12 months?

IF FEMALE:

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Completed

disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease or condition resulting in death) Due to (or as a consequence of)

15. Decedent's Education (Specify only highest grade completed)

Due to (or as a consequence of) Jue to (or as a consequence o.).

College (1-4 or 5+)

4

23c If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death 1 Yes 2 No 9 Unknown

5 Other (Specify) Unknown

contributing to death but not resulting in the underlying cause given in Part I.

AMENDED 23a,27, per me, g930 8-17-12 sm

Fetal death

26 Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work?

28a. Date of Injury (Month, Day,Year) 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc.

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 30 Name and address of person who

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) July 24, 2012

28f Location (Street and Number or Rural Route Number, City

l6b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 X Unknown

death? 1 X Yes

24b. Were autopsy findings available prior to completion of cause of

Month

24a. Was an autopsy performed?

Yes 2 No

Other 1 Nursing Home 5 Residence 6 X Other Scene

or Town, State)

28d. Describe how injury occurred

Frederick, Maryland

MD 21701

Year

2 No

Approximate Interval Between Onset and

Technology

Information

18.Mother's Name (First, Middle, Maiden Surname)

(Street and Number or Rural Route Number, City or Town, State, Zip Code)

Kathleen Turner

13246 Wonderland Way, Germantown, MD 20874 July 28,

2012

3 Ectopic pregnancy

Resthaven Funeral Services, Skkot Cody 9501 Catoctin Mountain Hwy. Frederick,

900 W. Baltimore Street, Baltimore, MD 21223

Theodore M. King, Jr., MD. Assistant Medical Examiner 31 Date filed (Month Dily, Year) 32. Registrar's Signature

RABRAGA

1041

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep Registrar  Ce	artment of Health and M	1ental Hygie	2012	24483
	Dhuoisia		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia Medic		Francis Edward Cole Jr		July 1	0 2012	5:50 PM
-	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		Frederick Memorial Hospital  5. Social Security Number   6. Sex   7. Age (In vrs. last birthday)	Frederick  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Freder	ick ace (State or Foreign
	Director		219-34-8382 1 M 2 D F 74 Yrs.	Months Days Hours Min.	(Month, Day, Yea	ar) Counti	ace (State or Foreign y)
	A C		Usual Residence of Decedent		April 6,1		ngton DC
	iryland I-f sh ied a	Director	10a. State 10b. County 10c. City, Town or Lo			10	d. Inside City Limits
	he Ma or 28a notif	Dire	Maryland Frederick Fredericl	10f. Zip Code	100	. Citizen of What Count	
	with ti	eral	8201 Lookout Lane	21702	Tog.	United Sta	
	leath items er mi	Funeral		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - America	n Indian,
36	after o	by	1 Never Married 2 X Married 1 Yes 2 X No	1 Yes 2 X No Specify:	nicali, etc.)	Black, White, et	
8	ours a	etec	3 Uvidowed 4 U Divorced Year or Dates.	dent's Usual Occupation	140	WIII	
215	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at , the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give	kind of work done during most of worki O NOT use retired)	ng 160	o. Kind of Business/Ind	ustry
21	iled withii I Hygiene other th			crobiologist	Ţ	J. S. Army	
pu	e filed Ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	den Surname)	
rylë	should be file and Mental 7 is marked of raumatic eve		Francis Edward Cole Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	Edith W			
Ma	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Ye.	i i i i i i i i i i i i i i i i i i i	ng Address <i>(Street and Number or Rura</i> $1$ $\mathtt{Davis}$ $\mathtt{Mill}$ $\mathtt{Road}$ ,			
ē,	1 and 2 s of Health item 27 other tra		20a. Method of Disposition 20b. Place of Dispo	osition (Name of	ate 20c	. Location - City or Tov	
m	Page nent c ant: If iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State   cemetery, cree 4 ☐ Donation 5 ☐ Other (Specify)   Resthaver	natory or other place) 7/17 Nemorial Gardens	7/2012   Fr	ederick,Ma	rvland.
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signatur Funera Seyli e. enseey	2. Name and Address of Facility tauffer Funeral Ho 621 Opossumtown Pi	mes P A		
ш	00 E E 0	138				rick,Maryl	and 21702
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one dause on each line.  Immediate Cause (Final		r respiratory arrest,		Approximate Interval Between Onset and Death
	Enyuician. Medical	- 10	disease or condition MYDCARDIA				Onset and Death
	Examiner		Due to (or as a consequence of):	MIA			
	- =	Examiner	Sequentially list conditions, b. Due to lor as a consequence of cause. Enter Underlying				
	cuted and transi	xam	Cause (Disease or injury that initiated events c.				
_	be executed sician and burial-transit	alE	resulting in death) Last Due to (or as a consequence of):				
Box 68760	cate be ex physician s the buria	Physician/Medical	d				
89	eath certificate attending phy I for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	7		23d. Date of deliver	y
ã	death	sicia	1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month E	Day Year
P.O.	it the	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the u	underlying equals given in Dort I			
ω, σ.	requires that the des been signed by the s should be detached	d by	Taken State Significant Solidations contained to Secure but not resulting in the	moonying cause given in rait i.		co use contribute to the	/
Sign	requi	lete			24a. Was an		sy findings available
ecc	e has age 2	Completed			autopsy performed	prior to com death?	pletion of cause of
<u>=</u>	sician; The certificate rector, pag	Be C	25. Was case referred to medical	26. Place of Death (Check	1 Yes 2 only one)	No 1 ☐ Yes 2	! □ No
ξ	Physici this cer ral direc	70 E	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	nt 3 DOA Other: 4 Nursing Hor	me 5 Residence	6 Other (Specify)	_
οι	iing Physician; The la n. After this certificate ha funeral director, page	ate:	27. Manner of Death 1 № Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) injury	work?	8d. Describe how in	njury occurred	
Sior	death ctor: / y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	19f Location /Ctroot	and Number or Dural E	Pauta Number
Division of Vital Records,	al or A s after I Direct		4 Homicide determined building, etc. (Specify)	eet, ractory, onice	City or Town, St	and Number or Rural F ate)	soute Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, an	d due to the cause(s	s) and manner as stated	1.
	To the H within 24 To the Fi complete	Me	(Check 2 ☐ Medical Examiner: On the basis of examination and/or invesonly one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge	, death occurred at the time, date and place			
	5 N W. T		29b. Signature and title of certification	29c. License number	29d.	Date signed (Month, Da	ay, Year)
	ii.		30. Name and address of person who completed cause of death (Item 23a) (Type, F	mbb71068		1 11 12	
	0		130, Name and address of person who completed cause of death (term 23a) (type, 1)	West 7th St	Frede	rick mo	21701
	Stat		31. Date filed (Month, Day, Kear) 32. Registrar's Signature	6.41	17 00		
	Registra	ar	JUL I (2012 Menera B. A	barke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NAOMI CURRIN JULY 14 12:00P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death VILLAGE AT ROCKVILLE MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) AUG • 3 , 1920 **Funeral** . Social Security Number 203-05-2259 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days PENNSYLVANIA 1 □ M 2 F Director 91 Yrs. 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours efter death with the Maryland Director Page 1 and 2 should be filed within 72 hours efter death with the Maryla ment of Health and Mental Hygiene. It is marked other than "natural", or items 23e or 28e-f stort. If item 27 is marked other than "natural", or items 23e or 28e-f story or other traumetic event, the Madeal Evanniner must be notified. MD. MONTGOMERY ROCKVILLE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9701 VEIRS DRIVE 20850 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 ☐ Yes 2X No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NICHD FED. GOVT YRS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM TURNER DOROTHEA DIMMICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE CURRIN- DAUGHTER 13845 GREY COLT DR., N. POTOMAC, MD. 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p permit, Page 1 s
Depertment of H
Importent: If ite
eny injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State METROPOLITAN CREM. 7/15/2012 4 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA, VA. 22. Name and Address of Facility 22 - WISCONSIN - WASHINGTON, DC Signature of Funeral Service Lic CC0367 HYSONG CO. WASHINGTON, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to infinediate cause. Enter Underlying Due to for as a consequence of: burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last ettending physician for use as the buria Physician/Medical Hospital or Attending Physicien: The law requires that the deeth certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Day Year signed by the eight Yes 2 W 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, Completed 1 Yes 2 10 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 2 🗆 No 1 🗌 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defitying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 55m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHARLES W. KARESH -9701 VEIRS DR. ROCKVILLE MD 20850 31. Date filed (Month State Registrar

2-05387 imberley Kay		1-For State Certificate of Dea	Ith and Mental H	_	20	12 244
ysician/ Med Exam	cal	Dacedent's Name (First, Middle,Last)     KIMBERLEY KAYE CARPER		2. Date of Death	Day Year	3. Time of Death 0629 hrs
			Town, or Location of Daath	odiy 10, 201	4c. County of Death Washington	1
Funeral		226-12-261/I	der 1 Year   If Under 24Hrs		MM/DD/YYYY) 9. Bir	thplace (State or Foreign
Director		Usual Residence of Decedent	Tis Days   Floors   William	5/19/1	962	VA
Maryland 28a-f show any d at once,	_	10a, State 10b, County 10c, City, Town or Location HAGERSTOWN				10d. Inside City Limits 1 Yes 2XX No
the Marylan a or 28a-f s tified at one	Director		p Code 21740	10g.	Citizen of What Cour USA	ntry?
ter death with ", or items 23 er must be no	/ Funeral	1 Naver Marriad 2 Married Armed Forces? If Yes, spec  3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto 2 No specify:		White, etc.	ican Indian, Black,
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Feather and Mertal Hygiene. Important: of Feather 11st marked other than "natural", or kerns 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual during most of we	Occupation (Give kind of woorking life. DO NOT use retir	ed)	6b. Kind of Businass/I	ndustry STRIBUTION
21215-0036 ould be filed within 7 l Mental Hygiene, i marked other than ic event, the Medica	Be Con	17 Father's Name (First, Middla, Last) WILLIAM ELMER CARPER	18.Mother's Name MARY KA			
MD 21 rd 2 should alth and Me m 27 is ma	욘	19a. Informant's Neme/Ralationship (Typa, Print.)  MARY K. CARPER/MOTHER  19b. Mailing Address 9107 CHAF	s (Street end Numbar or I RLES TOWN ROA	Rural Route Numbe ND,CHARL	r, City or Town State, ES TOWN,	<sup>Zip, Code</sup> 1 WV 25414
Baltimore, permit. Pages 1 and Department of Heal Important: If iten injury or other tra		20a. Method of Disposition  1 Burial 2 XXcremation 3 Removal from State  4 Donation 5 Other Specify  20b. Placa of Disposition (Nar crematory or other place SMITHSBURG CREW)	ATORY JUL	Y 21,	Oc. Location - City or SMITHSBURI	G, MD
Balt permit. Departu Import injury		2	d Address of Facility BRI KING ST., MART		. HOME, PO B √ 25402	OX 821,
Physician /Medical Examiner		Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of failure. List only one cause on each line.      Immediate Cause (Final disease a Contact Gunshot Wound of Head.	if dying, such as cardiac or i	respiratory arrest, s	shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death)  Due to (or es a consequence of):  Sequentially list conditions,				
	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
cuted und transit	ш	events resulting in death) Last  Dua to (or as a consequenca of).  d.				
O, e be exe ysician a burial -	edical	UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, To the Hopkal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Puneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yas, outcome of pragnancy   1 Live birth   2 Fetal death   4 Pregnant at time of death   5 Other (Special Content of the content		ncy	23d Date of delivery Month C	ey Yeer
P.O. B es that the d igned by the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		cco use contribute to t	
ds, P.O	eted		· · · · · · · · · · · · · · · · · · ·	24a. Was an		topsy findings available
of Vital Records, sgPhysician: The law require offer this certificate has been si meral director, page 2 should b	Completed		7.5 W	autopsy performe		completion of cause of
fital sician: is certifi lirector,	Be	examiner? Hospitel: 1 Input ant 3 FR (Outpet at 1	26.Place of Death (Check of DoA Other Nursing		sidence 6 X Other	Scene
n of V ding Phy After th funeral	on: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 1 Death 28a. Date of Injury 28b. Time of Injur	28c. Injury at Work?	28d. Describe how Subject shot s	injury occurred	Scene
Division  To the Hospital or Attendit within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification	2 Accident Investigation Jul 18 2012 0629 hrs  3 X Suicide 6 Could not be determined (Specific Scients Specific Scients Specific Specific Scients Specific S	y, office building, etc.	28f Location (Stre or Town, State	et and Number or Rui ) Hagerstown, M	
To the Hospit within 24 hour To the Funer completely fill	ca	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the	time, date and place, and d		and menner as stated	aurodo)
Toth withi Toth comp	Medi	and manner stated.	c. License number		ed. Date signed (Mo)	

State Registrar

Theodore M. King, Jr., MD.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrer's Signature

O.C.M.E.

OCME

29d. Date signed (Month, Day, Year)

July 19, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State 7/17/12, M.S. Kent Co. Registrar Amended#17 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RICHARD M. DONCASTER, SR. MD JULY 12 **2**012 8:30 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER MANOR CHESTERTOWN KENT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F **Director** 92 Yrs. 0770471920 182-36-7842 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD **KENT** WORTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24147 UNIVERSITY DRIVE 21678 UNITED STATES 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 hours after If Yes, Give Year or Dates. **WWII** 1 ☐ Yes 2X No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ SURGEON MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ည TRALL DONCASTER William Trall Doncaster JANE MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health item 27 RICHARD DONCASTER, JR. / SON 530 LAKE OF THE WOODS BLVD. AKRON, OHIO 44333 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 a Date 20c. Location - City or Town, State Important: If i any injury or c cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 07/14/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final -Promician/ RESTRICTIVE LUNG DISEASE disease or condition resulting in death) nears Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Directo (or as a consequence of) cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be Box 68760 inding pure IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? for Month Dav Year Pregnant at time of death Yes 2 No Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, CHRUNIC OBSTRUCTIVE RULMONARY DISGASE Completed 1 Yes 2 No 3 Probably 4 Unknown RIGHT SIDED CONGESTIVE HEART FARURE 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page performed? Yes 2 No 1 ☐ Yes 2 █ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **Z** No Other: <u>ا</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical t 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 0041587 2012 8 Name and address of person who completed cause of death (Item 23a) (Type, Print) chostortown, MD 21620

Registrar DHMH 17 Rev 7/2009

State

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2-05128			ype or Print in								ible.	
amoude Dona			State of Marylan					d Ment	al Hygier	ne	20	12 244
		1- For State Registrar		Ce	rtifica	ate of Dea	ith			Re	g. No.	12 644
Physici	an/	Decedent's Name (First, Michael Control of the	ddle,Last)							e of Death	1	3. Time of Death
Medical Exam		Yamoul D	ona						Moi July	nth / 8, 201	Day Year 2	1100 hrs
		4a. Facility Name (if not institu		per)		4b. City,	, Town, or	Location of			4c. County of Dea	ith
		219 Old Denton Roa	· -				eralbur				Caroline	
Francis		5. Social Security Number	6. Sex 7.	Age (In yrs. 1	aet hirth		der 1 Yea		24Hrs 8 D	ate of Rint	(MM/DD/YYYY) 9. B	lirthologo (State or
Funeral Director				Age (III yis. I	ast Dirti	Mont			Min		Fore	ign
Director		221-06-2108	1 X M 2 F	6		Yrs.			Au	ıg. 1	6, 2005 °	Country) Haiti
		Usual Residence of Decedent										
any		10a. State 10b. Count	ty	10c. City,	, Town	or Location						10d. Inside City Limits
nd <b>show</b>	_	MD Caro	line	Fed	dera	lsburg						1 X Yes 2 No
Maryland 28a-f show d at once.	ctc	10e. Street and Number		_			ip Code			10	g. Citizen of What Co	untry?
MD 21215-0036 1.2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 1.27 is marked other than "natural", or items 23a or 28a-7 sho umatic event, the Medical Exteniner must be notified at once.	Director	118 Old Dento	n Rd.			2	1632				Haiti	
ith the 23a noti		11. Marital Status	12. Was Deced	ent Ever in II	9	13. Was Deced			n2 / Specify V			erican Indian, Black,
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alt mit. sparts port jury		21. Signature of Funeral Service	ce Licensee			22. Name and						
മ ಕಳ್ಳಾತ		Christine	M. Coal	L		Framp	otom	Funer	al Home	e, Fe	deralsburg	g, MD
Physician		23a. Part I. Enter the disease, failure. List only one caus		ed the death	. Do not	t enter the mode	of dying,	such as car	rdiac or respira	atory arres	st, shock, or heart	Approximate Interval Between Onset and
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x 6 h cer lendii	Cia	past 12 months?	4 Pregnan	at time of de		Other (Spe						
BO) deatl	Physician/M	1 Yes 2 No 9 U	Jnknown 9 Unknown	n								
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ires that the signed by	و								1	Yes	2 No 3 Pro	bably 4 Unknown
ords, w require ts been si should b	ted								124	a. Was ar	1 24b. Were a	utopsy findings available
COFC law re has be	H									autopsy	prior to	completion of cause of
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Vital Reconstitute In the land in secretificate had director, page 2		25. Was case referred to media					26.Place	of Death (C	Check only one	∍)		
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Hoo 24 h Fun			Physician: To the best of									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ledical	one) 2 Medical Ex	xaminer:On the basis of e and manner state	examination a	nd/or in	vestigation, in m	ny opinion	, death occ	urred at the tin	ne, date ar	nd place, and due to t	he cause(s)
F 3 F 8	₹ ¥	29b. Signature and title of certi				29	c. Licens	e number		T	29d. Date signed (Mo	onth, Day, Year)
		In a	~ . 00				O.C.I	M.E.			July 9, 2012	
		2000			00							
- 1		30. Name and address of personal including MD. Assist	on who completed cause o tant Medical Examii	-		ltimoro Str-	of Dal	imore #4	D 21222			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $2 \, \cap$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 07 2012 Homas 23 /Medical 6:45 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4 Lemmert Street Frostburg Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Sex 1 M 2 □ F **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Director 220-38-2321 12-21-1940 Maryland Usual Residence of Decedent 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Exemitive must be redified at 10c. City, Town or Location 10d. Inside City Limits Allegany Director Frostburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Lemmert Street Funeral 21532 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No 1958
If Yes, Give
Year or Dates: /96/ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any injury or other traumatic event, Item any injury or other traumatic event, Item Magnee. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Sheet Metal Worker Sheet Metal 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Davidson ည Laura Shaffer Davidson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Davidson wife 4 Lemmert Street Frostburg, MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Cumberland Crematory 07-24-2012 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 22. Name and Address of Facility Sowers Funeral Home, P.A. 21. Signature of Funeral Service Licensee MO0547 60 W. Main St Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) BAKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physlcian: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached f 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2-1No 1 ☐ Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1. Natural 28h. Time of 28d. Describe how injury occurred 5 Pending 24 hours after death 1 ☐ Yes 2 Accident investigation 2 🗆 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar HIGHWAY LAVALE, MD 21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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amend #23a per MD FCHD TM 7/17/12 State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1644pM Dickinson William 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hosp 1+W Johns Hopkins 8. Date of Birth (Month, Day, Year) Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Min. **Director** 020-34-3113 1 🖾 M 2 🗆 F Sept.3, 1945 Massachusetts Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29020 Ridge Road 21771 United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian. Black White etc. "natural", or þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. Vietnam Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any righty or other traumatic event, the Medical. once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Trainer State of Pennsylvania Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William A. Dickinson Margaret Droney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan McDavid / Sister 29020 Ridge Road, Mt. Airy, Maryland, 21771 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Stauffer Crematory Inc.7/5/2012 Frederick, Maryland. Name and Address of Facility
tauffer Funeral Home P. A.
East Ridgeville Blvd, Mt. 21. Signatur eral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Idiopathic Thrombocytopenic Purpura Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 24 hours after death. Funeral Director: After this certificate I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 🗹 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending I 24 hours after death. 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2. Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) Res-000 Mx and apuress of person who completed cause of death (Item 23a) (Type, Print) 1800 Orleans St Battimore 91 31. Date filed (Month gistrar's Signature State Registrar

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edical Exami	ner	Marguerite E. Dang	- 10	011 T		Month July 21,				1208 hrs
		Facility Name (if not institution, give street and number)     7558 Annapolis Road		. City, Town, o		of Death	- 1	4c. County of Prince G		S
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last bird)		If Under 1 Ye		r 24Hrs. 8. Date of			g. Birth	place (State or
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talti rmit. epartir nports jury o		21. Signatur of Funeral Service Licensee		me and Addres		100110011/11				ome
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To To con	Mec	and manner stated.  290 Signature and title of certifier			nse number			. Date signe		
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OCME		30. Name and address of person who completed cause of death (Item 23a)	) W Pal	timoro Stra	of Baltim	oro MD 24222				
St	ate	Laron Locke MD. Assistant Medical Examiner 900  31. Date filed (Month Day Yea) 32/ Registrar's Signature	vv. ball	uniore Stre	ei, Dailiff					
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			State Registrar		Cer	tificate of	Death		Reg. No. 2	012	2449
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-	Medic Examin		4a. Facility Name (if not institution, give s	Freddie Deel, street and number)	Sr.	4b. City. Town.	or Location of Dea		20 2 4c. County		1300 P <sup>M</sup>
4			647 Lombard Road				ig Sun		1 - 1	ci1	
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	and show at		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	cation				10	d. Inside City Limits
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98	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>م</u>	1 D Never Married 2 🕅 Married	Armed Forces? $1963$ 1 $\times$ Yes 2 $\times$ No $1966$ If Yes, Give	- 1	Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puer	to Rican, etc.)		ck, White, e	
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ary	hould and Me s marl umati		19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailin	g Address (Street	t and Number or R			State. Zip Co	ode)
Σ	nd 2 s ealth a m 27 i		Donna Deel/Wife		ı		Road, Ri			1911	
Baltimore,	ge 1 a nt of H :: If ite or oth		20a. Method of Disposition 1 $\square$ Burial 2 $X$ Cremation 3 $\square$ f	Removal from State ce	metery, crem	sition (Name of natory or other pla		ly 25,	20c. Location	-	
ltin	nit. Pa artmei ortant injury		4 ☐ Ponation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	<del></del>		is & Co.,	ess of Facility H	12			ter, PA
Ã	permit Depar Impor any in		1 Jonus &	thinks.			Stockto				•
	Physician/ Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	e cause on each line.	lusion ence of):		ng, such as cardia		rest,		Approximate Interval Between Onset and Death
0	te be executed lysician and ne burial-transit	ical	resulting in death) Last	Due to (or as a conseque	ence of):						
. Box 6876	Attending Physician: The law requires that the death certificate be executed or death.  ector After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi		F FEMALE: 23b. Was decedent pregnant In the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de g ☐ Unknown	death 3	Ectopic pregnan Other (specify)	icy			te of deliver	y Day Year
s, P.O.	Flaw requires that the de has been signed by the ge 2 should be detached	d by P	Part II. <b>Other significant conditions</b> con	tributing to death but not resul	Iting in the un	nderlying cause g	iven in Part I.		obacco use contr		cause of death?
ord	iw requ	plete						24a. Was		Were autops	sy findings available pletion of cause of
Re	ding Physician: The la th. After this certificate ha funeral director, page	Sol						perfo	rmed?	death?	
ital	ician: certific rector,	Be	25. Was case referred to medical examiner?	ospital:		Oth	Place of Death (Che				
of V	y Physer this eral di	e:	1 ☐ Yes 2 🔀 No 🗔		8b. Time of	28c, Iniu	4 ∐ Nursing I rv at	128d, Describe h	dence 6 Other		
on	ending eath. or: Aftu he fun	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 □	k? Yes 2 No				
Division of Vital Records,	Dir	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (S City or Tow	street and Numbern, State)	er or Rural F	oute Number,
	Hospi 24 hou Funer leted fill	Medical	(Check 2 L Medical Examine	cian: To the best of my knowled er: On the basis of examination a Practioner: To the best of my l	and/or investi	gation, in my opini	ion, death occurred	at the time, date a	nd place, and due	to the caus	e(s) and manner stated.
	To the vithin to the comp		29b. Signature and title of configuration	* ractioner: To the best of my r	vilowieuge, ut	29c, Licens			29d. Date signed		
			30. Name and address of person who con	M	D	D	00621	90	7/2	14/1	2
5X	1 10		30. Name and address of Berson who co	mpleted cause of death (Item 2	3a) (Type, Pr	twy, S	NAWAZ	KHAN	MD	1.7	, MD 21915
	Stat	_	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	P	- 7, 5	OITE A	~ 11CJ/1	rent	417	בון ול עדיין
	Registra	r	AUG 0 1 2012	brewa B. B	area						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7 Dorothy Mildred Fletcher 6:16 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury OSDICE 0 asta WICOMICO the Late Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year)
Nov. 22, 1921 Director 215-16-3133 Country) 90 1 🗆 M 2 🔀 F Maryland Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Wicomico Mardela Springs MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21837 11205 San Domingo Road United States death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimoré, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: ould be moderned.

Ind Mental Hygiene.

S marked other than "natural". 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the B&G Pickle Co. Food Processor (Grad.) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental H item 27 is marked of Sally Phillips Charles Monroe Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Iola Brown/Daughter 11205 San Domingo Rd., Mardela Springs, MD 21837 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ott once, Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Eastern Sh. Veterans Cem. 07/10/12 Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final CRREBROVASCULAR Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to for as a consumence of cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 22 No 1 🗆 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending Investigation 1 Yes 2 No within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition in the desired of the des (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARE mp 2180L 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 9 2012 Registrar DHMH 17 Rev 06-2011

X53

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $J_{u}^{\text{Month}}$ Doris Janet Flickinger 11 2:05 P M . Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll 8. Date of Birth
(Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 □ M 2 🔀 F Days Months Director 214-28-5028 80 Usual Residence of Decedent show 10a. State items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 Butterfly Drive 21787 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No the Medical Examiner Black, White, etc. <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural" Completed 3X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Bookkeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked of ည Luther Angell Florence Koontz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Flickinger / Son 5150 Harney Rd., Taneytown.  $MD_{21787}$ item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 Department of I Important: If its 1 Nourial 2 Cremation 3 Removal from State Resthaven 4 Donation 5 Other (Specify) 7/16/2012 Frederick, Maryland 21. Signatura of Funeral Service License Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Enter the dispase or complications that cursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last -trar Due to (or as a consequence of): Physician/Medical Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown signed by the ar 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury Certificate: injury 1 Natural 5 Pending s after death.

I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

Registrar

DHMH 17 Rev 7/2009

State

egistrar's Signature

1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ JULY 15, LOUIS C. GETZ, JR. 8:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT 7. Age (In yrs. last birthday) **Funeral** Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F (Month, Day, Year) 04/15/1940 Hours 72Yrs. Director 181-30-5791 PENNSYLVANIA Usual Residence of Decedent show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 XNo MD **KENT** ROCK HALL 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 5788 LIBERTY STREET P.O. BOX 47 21661 UNITED STATES items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by ō 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: 3 Widowed 4 X Divorced Year or Dates WHITE and Mental Hygiene.
is marked other than "natul
aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SERVICE MANAGER 12 AUTOMOTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည LOUIS CHARLES GETZ, SR. other traumatic HELEN WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau NICOLE FRAZIER / DAUGHTER 202 TONKIN STREET BEAVERTON, MI 48612 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 07/16/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MMON 14 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Box 68760 as) attending IF FEMALE: asn s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death Year 1 Yes 2 L 9 Unknown the a 9 Unknown P.O. by s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MULIT Adduct Records, 1 Yes 2 No 3 Probably 4 Unknown Completed BOURT LIKERY DUFTO DIVENTICULIE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 s performe certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL

00060301

ROOP RD STES CHESTERAN IND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death 8. Date of Birth (Month, Day, **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs . Birthplace (State or Foreign Country) **Director** 84 214-32-1159 1 M 2 X 1-25-1928 MD ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Queen Anne's MD Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 331 North Liberty Street 21617 USA ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: "natural", 3 Divorced Specify: Black Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Bus Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked or other traumatic eve ည william Douglas Gaines Annie Lavenia Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Gaines/ 329 N. Liberty ST Centreville, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date Male and Female Beneficial Lodg 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/13/2012 Centreville, MD 4 ☐ Donation 5 ☐ Other (Specify) Lodge 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Funeral Service Licer 855 High ST Chestertown, MD 21620 m 23a, Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nediate Cause (Final Onset and Death Phintician. disease or condition Medical resulting in death) **Examiner** figurations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Pregnant at time of death Unknown signed by the at be detached for 1 Yes 2 been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completely filled in by the funeral director, page 2 s autopsy 2/1 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. .Dav. Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rm KERSON GRASM VILLE NOEL gistrar's Signature State Registrar

12-05131 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Christopher Toto Gabriel State of Maryland / Department of Health and Mental Hygiene 2012 24496 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 8, 2012 1320 hrs **Medical Examiner** Christopher Gabriel 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Federalsburg 219 Old Denton Road Caroline 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director Sept.30,2000 Country) Haiti 769-84-6649 1 XM 2 F Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show Federalsburg Caroline Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Haiti 3464 Laurel Grove Rd. Apt. 21632 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 1 Yes 2 X No Widowed If Yes, Give Year 1 Yes 2 X No specify: Specify: Black 2 fealth and Mental Hygiene.
item 27 is marked other than "natur:
traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student 5th Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Francois Gabriel Rosemane Maxi Gabriel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francois Gabriel/father 3464 Laurel Grove Rd. Apt4D, Federalsburg, MD 21632 Health 8 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Federal Hill Cemetery 7/15/2012 Federalsburg, MD 4 Donation 5 Other Specify: Signature of Funeral Service Licenses 22. Name and Address of Facility Coale Framptom Funeral Home, Federalsburg, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami ficineess or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED attending physician or use as the burial -AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) 1 🗸 Y

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this After within 24 hours after death To the Funeral Director: in by the

examiner	THos	pital:	1	(1	Other Nurs		
1 <b>✓</b> Yes 2	No	1 Inpatient 2	ER/Outpatient 3	DOA	Nurs	ing Home 5	Residence 6 🗸 Other: Scene
27. Manner of Death		28a. Date of Injury	28b. Time of Injury	28c. Inju	ry at Work?	28d. Describe h	now injury occurred
1 Natural 5	Pending	FOUND: Day, Year)	FOUND:	1 .	Yes 2 ✔ No	Subject drov	vned
2 🗸 Accident	Investigation	Jul 8, 2012	1320 hrs	,	103 2 🕎 110		
3 Suicide 6	Could not be	28e. Place of Injury - At he	ome, farm, street, facto	ry, office b	ouilding, etc.		treet and Number or Rural Route Number, Ci
4 Homicide	determined	(Specify) Creek				or Town, St 219 Old Dento	on Road, Federalsburg, MD
29a. Certifier 1 Certifier	fying Physician:	To the best of my knowled	ge, death occurred at t	ne time, da	ate and place, an	d due to the cause	e(s) and manner as stated.
one) 2 🗸 Medi		n the basis of examination a id manner stated.	and/or investigation, in r	ny opinior	, death occurred	at the time, date a	and place, and due to the cause(s)
29b. Signature and title o	f certifier		2	9c. Licens	e number		29d. Date signed (Month, Day, Year)
In	i an	A.		O.C.	M.E.		July 9, 2012

900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year, State Registrar

Ling Li, MD

Medical

32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylaı		artment of F		nd Mental Hy		201	2 2449		
		_	Registrar  1. Decedent's Name (First, Middle	e Last)	tillcate of L	Jeann	2, Date of De	neg. No.						
	Physicia Medic		John Edward G	July				Day Year 7 2012 2:40 F						
-	Examin	er	4a. Facility Name (if not institution Genesis Heal	nes	4b. City, Town, or <b>Ea</b>	Location of ston	Death	4c. County of Death  Talbot						
	Funeral Director		5. Social Security Number 213–28–3587	6. Sex 1 💢 M 2 □ F	If Under 1 Year Months Days	If Under 2 Hours		9. Birthplace (State or Foreign Country) Mary Land						
	, M		Usual Residence of Decedent											
	ryland -f sh ied at	cto	10a. State 10b. County			ity, Town or Lo	cation					10d. Inside City Limits		
	r 28a notif	Dire	MD Talb  10e. Street and Number	ot	Eas	ton	10f. Zip Code			10 0'''	izen of What Cou	1 🗆 Yes 2 🔀 No		
	s 23a c ust be	Funeral Director	7055 Pine Ridg	e Rd.			21601			United				
9	iter death , or item aminer m		11. Marital Status 1 □ Never Married 2 🂢 Ma	12. Was Deced Armed Ford 1 🔯 Yes If Yes, Give	es?	1	f Yes, specify Cuba	n, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)		14. Race - Amer Black, White	, etc.		
003	tural"	Completed by	3 Widowed 4 Divorced	Year or Dat	es. 1950		1 ☐ Yes 2 💢 No			. !	Specify: White			
15	72 ho n "na"	nple	15. Decede (Specify only high	(Give	dent's Usual Occup kind of work done o O NOT use retired)	ation Iuring most o	of working	16b. Kir	16b. Kind of Business Industry					
212	within giene. er tha the N		Elementary/Seconday (0-12)	College (1-4	l or 5+)	1	Pres. of	Manufa	acturing	Blac	ck & Dec	ker		
2	filed all Hyg		17. Father's Name (First, Middle,	Last)					's Name (First, Middle,		,			
yla	Ment Ment narke	입	John E. Gerber	•				Thelr	Gerbe	erber				
Maryland 21215-0036	d 2 shoualth and 127 is ner traum		19a. Informant's Name/Relations  Joanne M. Gerb				ng Address (Street and Number or Rural Route Number, Pine Ridge Rd., Easton, l							
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 🔀 Cremation 4 □ Donation 5 □ Other (	3 ☐ Removal from S	State	cemetery, cren	sition (Name of natory or other plac remationC		Date 7/9/2012		cation - City or I			
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	Licensee $\mathcal{U}$ $\mathcal{C}$	acle				Mid Shore			enter		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
- 4	nysician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)  a. Adult Failure to tunive Due to (or as a consequence of):  Advanced Senile Demention  Years											
	Examiner		resulting in death)	Due to (o	d Van	juence of):	Semila I	\	1.			1444 18		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):									years		
	ecuted and I-transi	Exam	Cause (Disease or iinjury that initiated events resulting in death) Last				140							
09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	d											
876	tifical ng ph		IF FEMALE:	T		-								
Box 687	ith cer ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?		irth 2 🗌 Fet	al death 3 🗌	Ectopic pregnanc	у		2	23d. Date of deli	very Day Year		
Bo	ne dea / the a ched fi	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unkno	ant at time of wn	death 5 L	Other (specify)				WOITH	Day Teal		
P.O.	that th	by Pł	23e. Dig								tobacco use contribute to the cause of death?			
ds,	v requires s been sign should be	ed k	Hypertension	, chronick	idne	1 disc	ase, PV	D,	1 🗆	Yes 2	□ No 3 □ Pro	obably 4 Unknown		
Division of Vital Records,	law rec nas bee	Completed	Hypertensian Atrialfibrill	ation, R-	femur	frace	ture, m	ultp	24a. Was	psy	prior to co	opsy findings available ompletion of cause of		
Re	<b>Physician</b> : The lav r this certificate has eral director, page 2	Co		po thyroic	lison				1 🗌 Yes	2 No	death? 1  Yes	2 - NO		
/ita	sician certif irector	m	25. Was case referred to medic examiner?  1 ☐ Yes 2 ☑ No	Hospital:		15000	Othe	ar /	(Check only one)	10-10-00-00-00-00-00-00-00-00-00-00-00-0				
Jc V	y Physer this eral di	e: To	27. Manner of Death	28a. Date of	finjury	ER/Outpatier 28b. Time of	t 3 ☐ DOA 28c. Injury		sing Home 5 Resident			y)		
ouo	ending tath. rr: Afte ne fun	licat	1 Natural 5 Pendii 2 Accident Investi	gation	, Day, Year)	injury	M 1 🗆	? Yes 2□N	lo l					
Visi	or Atter fter de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	pined 28e. Place of	f Injury - At h		eet, factory, office		28f. Location (S		Number or Rura	al Route Number,		
	spital c		29a. Certifier 1 Certifying	Physician: To the be	st of my know	vledge, death o	occured at the time,	date and pla	ace, and due to the ca	use(s) and	d manner as stat	ed.		
	the Hc nin 24 the Fu rpleter	Medical	(Check 2 Medical I only one) 3 Certifying	Examiner: On the basis Nurse Practioner: To	of examination	on and/or invest	igation, in my opinio	n, death occi	urred at the time, date a	and place,	and due to the ca	ause(s) and manner stated,		
	North		29b. Signature and title of certifie				29c. License	number 2359		29d. Date	e signed (Month,	Day, Year)		
			30. Name and address of person	- 1	of death (Iter	n 23a) (Type, P		J. J. J		- 1	1110			
			610 Dutch		Eas	ton M	9 216	01	Stefani	e r	Detigl	ia		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Rec	istrar's Signa	The state of the s								
	1H 17 Rev 7/20	.00	300											

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 24498

						Cer	tificate of	Death			Reg. No	).			
	Physicia	an	1. Decedent's Name (First, Middle, L	ast)	C ^	- 1 >		•		2. Dete of De Month	eath De	y	Year	3. Time of Death	
4	/Medic		CHARLES 1. GANDAL							July	2 2012		2	1:30 pm	
	Examin	er	4e Fecility Neme (If not institution, g		nber)			4b. City, To	wn, or Lo	cetion of Deat	h 4c.	. County o	f Deeth		
													.bot		
	Funeral		Social Security Number     6.	Sex 1DXM 2□F	7. Age (In yrs. la: 84		If Under 1 Year Months Days	If Under	Min.	8. Date of Bir (Month, Da	ay, Y <i>ear)</i>		Birthplece (State or Foreign Country)		
l.,	Director		055-20-2109 1LXM 2 F 84 Yrs. 2/19/1928 2/19/1928										New	York	
and	\$ <u>1</u>													0d. Inside City Lim	
Aaryl	show	5	MD		,		_							1 □ Yes 2 🛣 I	
the h	28a	Director	MD Talk	OC			10f. Zip Code	<u> </u>		, ,	10- 04	izen of Wi	Court		
with	0 8	ក់							•						
ath	23	Funeral	4625 White Marsh		da at Essa in 11 0	40.3		21673	-0.40	** *** ***		nited			
er de	重量	Š	11. Marital Status	Armed For	dent Ever in U,S. ces?	13. 9	Vas Decedent of F f Yes, specify Cub	en, Mexican	, Puerto l	Rican, etc.)	0-	14. Race Black	White,		
72 hours efter death with the Maryland	utal Hygiene. Indoorher than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	9	1	Yes 2XNo	Specify:				Specify:	Wh	ite	
hou	E E					16a Dagad	lestic Havel Occur	ation			16h V	ind of Duo			
	362	Completed	15. Decedent's E (Specify only highest g	rade completed)		(Give	lent's Usual Occup kind of work done DO NOT use retired	du <i>ring</i> mosi	of worki	ng		ind of Bus			
vith.	than the	티	Elementary/Secondary (0-12)	College (1-	-4or 5+)		octor	<i>-</i> /			vete	erina	rian	Medicin	
filed within	their nt.		17. Father's Neme (First, Middle, Las	5+				18 Mothe	r'e Namo	(First, Middle	Maiden	Sumama	)		
be	e o o	Be	Paul Gandal	•/				_			, maiden	,			
should	nd Mental Hygiene. marked other than matic event, me Mi	ို				Sara Lewis  19b. Mailing Address (Street and Number or Rural Route									
12 s	2 00 m		19a. Informant's Name/Relationship								er, City o	or Iown, S	tate, Zip	Code)	
1 and	# CV -		Jean Kelly Ganda	1/Wife	OOL DIS	PO Bo	$0 \times 607$ , T	'rappe	, Mai			1673			
9	\$ 1 5		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3	☐Removal from S	State 200. Plac	netery, crem	sition (Name of natory or other plac	ce)	i	Date	20c. Lo	ocation - C	ity or I o	wn, State	
Pa	ury in		4 ☐ Donetion 5 ☐ Other (Spec		1	Shore	Cremati	on Cn	tr. '	7/3/12	Ca	ambri	dae.	MD	
permit.	Depart Import any inj once.		21. Signature of Funeral Service Lice	ensee		22	. Name and Addre	ss of Fecility	у						
8	0 5 5 8		+ Rame	_ 0	FSP -	F	ramptom	Funer.	al Ho	me, PA	, Fe	edera	lsbu	rg, MD	
	1	7	23a. Part1. Enter the disease, or cor	nplications that ca	used the death.	Do not ente	er the mode of dyir	ng, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between	
Ph	ysician		shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death												
	Medical		Immediate Cause (Final disease or condition resulting in death)  a. In an I to m  Due to (or as a consequence of):										į	1 week	
Ex	kaminer													1 4000	
П.	2.	ē	Due to (or as a consequence of):											2 4765	
rted	nsit	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying											T forms	
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certificate be executed	ding physician end ise as the bural-transit	æ	Cause Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):											- jeurs	
ficate	phy :	edical	resulting in death) Last  Due to (or as e consequence of):												
certi	nding use a	₹		d											
eath o	etten I for u	2	D A							1					
he d	chec	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause				
thet t	dete		Blad	der 11	nevTi	a				1 🗆	Yes 2	□ No 3	∃ □ Prob	ably 4 ☐ Unkno	
requires thet the death	been signed by the ette should be deteched for	d by								24a. Was	an autor	0.014	24h Wa	re autopsy finding	
requ	shoul	Completed									ormed?	psy	ava	ilable prior to npletion of cause	
Тъе јем	2 5	2	the design of the second of th										of d	leath?	
	ate peg	S I								10	Yes 2	LEVINO	1 🗆	Yes 21 No	
Physician:		Re	25. Was case referred to medical examiner?						of Death	(Check only	one)				
ysic	this ce ral dire	0	1 Yes 2 No	Hospital: 1 ☐ In	patient 2 EF	VOutpatient	3□ DOA Oth	er: 4 🗆 Nu	rsing Hon	ne 5 🖫 Resi	dence	6 □Other	(Specify	)	
l or Attanding Physician: The lew requires the	h. After th funera		27. Menner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of (Month	Injury 28 Dey Year)	Bb. Time of Injury	28c. Injur Wor	y et k?	2	8d. Describe	how injur	ry occurre	d		
Attanding	death. ctor: Af y the fu	äti	2 Accident investigation	on				Yes 2□1	No						
Atte	er de recto by ti	<u> </u>	3 Suicide 6 Could not l 4 Homicide determined	20e. Place C	of Injury - At homo g, etc. (Specify)	a, farm, stre	et, factory, office		2	8f. Location (			or Rural	Route Number,	
al or	ed in De	Certification:		Do noing	g, o.o. ( <i>Opcony</i> )					ony or you	,, 5.0.0	'/			
Split	hour iners ly fill	œ l	29a. Certifier 1 Certifying Pi	nysician: To the b	est of my knowle	dge, death	occurred at the tin	ne, date and	place, a	nd due to the	cause(s)	and meni	ner as sta	ated.	
To the Hospital	within 24 hours efter death.  To the Funeral Director: After completely filled in by the funeral of the funeral	edical	(Check only 2 Medical Exa	miner: On the bas end manne	sis of examination or stated.	end/or inv	estigation, in my o	pinion, deat	h occurre	d at the time,	date and	place, an	d due to	the cause(s)	
Toth	withi To the		29b. Signature end title of certifier	0 /	^		29c. Licens				29d. Dat	te signed	(Month, E	Day, Yeer)	
			VIMS11	und	9		H4	218	7		07	1-02	-7	817	
•		-	30. Neme end eddress of person who	completed cause	of death (Item 2)	3a) (Type F			*			- 2		- 1 6	
			0 . A - :	Illin(			rood Ar	Pa	cta	mb	2	16001			
19	200		31. Date filed (Month, Day, Year)	()	gistrer's Sgnatur	20	1		3 (0)	, ,,,,		. 5 - 1			
	State		JUL 9 9 2012		1 1. 1	THE SAME	e.								

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Samuel July 16 2012 Gattens 10:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Egle Nursing and Rehab Center Lonaconing Allegany 5. Social Security Numbe 217–14–4814 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Month, Day, Year) 02/08/1922 Maryland Director 90 1 🖾 M 2 🗆 F Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Allegany Barton 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23709 Middle St. 21521 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 Never Married 2 X Married Black, White, etc. ğ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fiber Manufacturer unknown Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Gattens Catherine Irene Mowbray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Gattens/ wife 1 and 2 s f Health s item 27 i 57 Jackson St, Lonaconing, Maryland 21539 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory 07/17/2012 permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home Wagne 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PREUMONIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Hijury that initiated events Due to (or as a consequence of): Examir ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Day Year ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? <u>\$</u> CONCESTIVE HEART FAILURE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? has autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29d. Date signed (Month. Day, Year) 126907 JULY 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harjit Sidhu, 925 Bishop Walsh Road, Cumberland, MD 21502 31. Date filed (Month, Day Year) 1 7 2012 State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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William Andrev	v Ga	1- For State	State	of Maryla	and / Dep	artment of ertificate of	Health a	and Menta	l Hygiene	egible. 20	12 2450	
) Physic	ian	Registrar 1. Decedent's Name (First	Middle,La	st)			Death		2. Date of De	Reg. No. ∋ath	3. Time of Death	
Physic Medical Exam	ine	WIDITH INDICH ONCENTY								Day Year 2012	0738 hrs	
,		4a. Facility Name (if not in Frederick Memor	stitution, give street and number) 4b. C					or Location of [	Death	4c. County of De	ath	
Funera		Social Security Number	6. S						Attack to Date of	Frederick		
Director		220-15-9284		M 2 F	29			ear If Under 2 ays Hours	Min	Birth (MM/DD/YYYY) 9. E	eign	
	•	Usual Residence of Deced		Z WI Z F		Yrs.	L L		April	8, 1983	Country) MD	
v any		10a. State 10b. Co	ounty		10c. City	, Town or Location	on				10d. Inside City Limits	
land f shov	ò	MD Fr	ederi	.ck	Fr	ederick					1 Yes 2 X No	
Mary r 28a- ed at	Director	10e. Street and Number 10f. Zip Code								10g. Citizen of What Co	untry?	
rith the Maryland 123a or 28a-f show 1801ffed at once.	a D		Ct.	140.114	<del></del>		21701			USA		
eath w items ust be	Funeral	1 X Never Married 2	Married	Armed Fo			Decedent of I s, specify Cub	Hispanic Origin? an, Mexican, Pu	( Specify Yes or Nuerto Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,	
after d	by FL	3 Widowed 4	Divorced	1 Yes If Yes, Give Year	2 X No	1	Yes 2X	No specify:		Specify: Whi	4.	
nours a	d be	15. Decedent's Education		or Dates: nly highest grad	e completed)	16a. Decedent	s Usual Occup	pation (Give kind	d of work done	16b. Kind of Business		
36 in 72 l ban "1	plet	Elementary/Secondary (	)-12)	College (1	,	- during mo	st of working II	fe. DO NOT use	e retired)			
-00. J. withi giene. ther the	Completed	17. Father's Name (First, M	iddle Last	2		mai	nt <u>enan</u> c	e super	visor	Court Ho	use	
215 e files tal Hy ked of	Be C	Gary Garlan								Maiden Surname)		
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiens a 27 is marked other than rumatic event, the Medica	일	19a. Informant's Name/Rela		ype, Print )		19b. Mailing	Address (Str	eet ano Number	Bromley or Rural Route Nu	mber, City or Town, Stat	e, Zip Code)	
MD Id 2 sh Ulth an In 27 i	1	Penny Garla	nd/mo	ther		3590 1	aisy R	Rd., Woo	dbine, M		, , , , ,	
ore, slar of Hea If itel		20a. Method of Disposition 1 Burial 2 X Cren	ation 3	Removal fro	20b. m State	Place of Disposit crematory or other	on (Name of c	emetery,	Date	20c. Location - City of	r Town, State	
Baltimore, permit. Pages 1 ar Department of Hee important: If ite		4 Donation 5 Other Specify: Stauffer Crematory 07/30/2012 Fre								2 Frederick	• MD	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Se	rvice Licen	see	1 2 / 1	Λ	me and Addre	ss of Facility	Stauffer	Funeral Ho	mes, P.A.	
Physician		23a. Part I. Enter the disease	e, or comp	lications that ca	used the death	Do not enter the	21 Opos	sumtown	Pike, F	rederick, M	D 21702 Approximate Interval	
/Medical	i n	Between On										
Examiner		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.  b.										
	Ļ											
	nine	if any, leading to immediate cause. Enter Underlying Ca	luse	Due to (or as a	consequence o	f):						
sd sit	Examiner	events resulting in death) Last Due to (or as a consequence of):										
xecuted n and 1 - transit	dical I											
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transi	ledi	IF FEMALE:					ше, дэ	30- 8-1	U-12 Sm			
Box 68760 e death certificate I the attending physical ed for use as the bh	Physician/Me	23b. Was decedent pregnant past 12 months?	in the	1 Live bir	utcome of pregath		death 3	Ectopic pre	gnancy	23d. Date of deliver Month	y Day Year	
OX (eath ce attend for use	sici	1 Yes 2 No 9	Unknown		nt at time of de	ath	(Specify)				,	
P.O. B that the de	Phy	Part II. Other significant co		9 Unknow		esulting in the und	larlying cause	givon in Rod I	220 Did to	obacco use contribute to		
P.O. es that the igned by	1 by					and the same	icitying cause	giveri ii) raiti.	U. II	s 2 No 3 Prol		
of Vital Records, Pog Physician: The law requires the this certificate has been signs neval director, page 2 should be d	Completed by			·-					24a. Was		itopsy findings available	
e law te has ge 2 sh	ם				<del>, ,</del>				autop	sy prior to or med? death?	completion of cause of	
tal Reco		25. Was case referred to me	dical				26 Place	e of Death (Che	1 Yes	2 No 1 Y	es 2 No	
Vital I sysician: this certifi director,	o Be	examiner? 1 Yes 2 No	H	ospital: 1 Inp	patient 2	ER/Outpatient :		Other C		Residence 6 Other		
of Vil	١	27. Manner of Death		28a. Date of (Month, D	Injury	28b. Time of Inju	ry 28c. Inju	iry at Work?		now injury occurred		
	atio		Pending nvestigation	fd 7-	24-12	fd 06:45	am	Yes 2 🗶 No	subject	took Oxyco	done	
Division pital or Attendiours after death.	ertification:		Could not b	v		me, farm, street,		ouilding, etc.	28f. Location (S	Street and Number or Rutate) 703 Robin	ral Route Number, City	
E e on	아	202 Cortifies		(Specify)		:Resider			Mt. Air	y,MD.	1.5	
To the Hosp within 24 hos To the Fune completely fi	Medical	(Check only	Examiner:	On the basis of	examination an	e, death occurred d/or investigation	at the time, da , in my opinion	ate and place, a n, death occurre	nd due to the caus d at the time, date;	e(s) and manner as state and place, and due to th	ed.	
<b>1</b>	ΨĚ	29b. Signature and title of ce		and manner stat	ed.		29c. Licens			29d. Date signed (Mor		
		11				7 ]	O.C.	M.E.		July 25, 2012	, - 27, . 346/	
	ŀ	30. Name and address of per					1					
		Russell Alexander		ssistant Me			Baltimore	Street, Balt	imore, MD 212	223		
Sta Regist	ate rar	31. Date filed (Month, Day, Ye	6 20	19 19	strar's Signatur	g. Som	41		_	0445		
	_		, ,	/4/6/2	control of	W + 25-50/50/50			- 0	CME		